

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirements of this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then place the remaining carbon papers, Pages 1 and 2, in the order in which they should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 28 shows any injury or other traumatic event, the medical examiner must be notified or advised.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Earl Joseph Abbott					2a. DATE OF DEATH MONTH DAY YEAR January 07, 1987			2b. HOUR 1 M	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Feb. 26, 1908		6. AGE (IN YEARS LAST BIRTHDAY) YRS 77		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		8b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Arbutus		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1143 Gloria Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) supervisor		12b. KIND OF BUSINESS OR INDUSTRY retail	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Baltimore Arbutus					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1143 Gloria Avenue 21227		
14. FATHER'S NAME FIRST MIDDLE LAST John E. Abbott					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Wheeler				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW2		17. INFORMANT Florence Abbott		17. ADDRESS 1143 Gloria Ave 21227			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe, End Stage Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Severe Atherosclerotic Cardiovascular Disease, Cachexia</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>82</u> , to <u>PRESENT</u> , 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>12-30</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/7/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Norberto Machiran				22e. ADDRESS 720 Maiden Choice Lane 21228					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 01/09/87		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Dorsey Howard Maryland			
24. FUNERAL DIRECTOR NAME Ambrose Funeral Home 1328 Sulphur Spring Road				25a. DATE REC'D. BY REGISTRAR JAN 8 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

WEST COAST BUREAU

CHICAGO W. CO.

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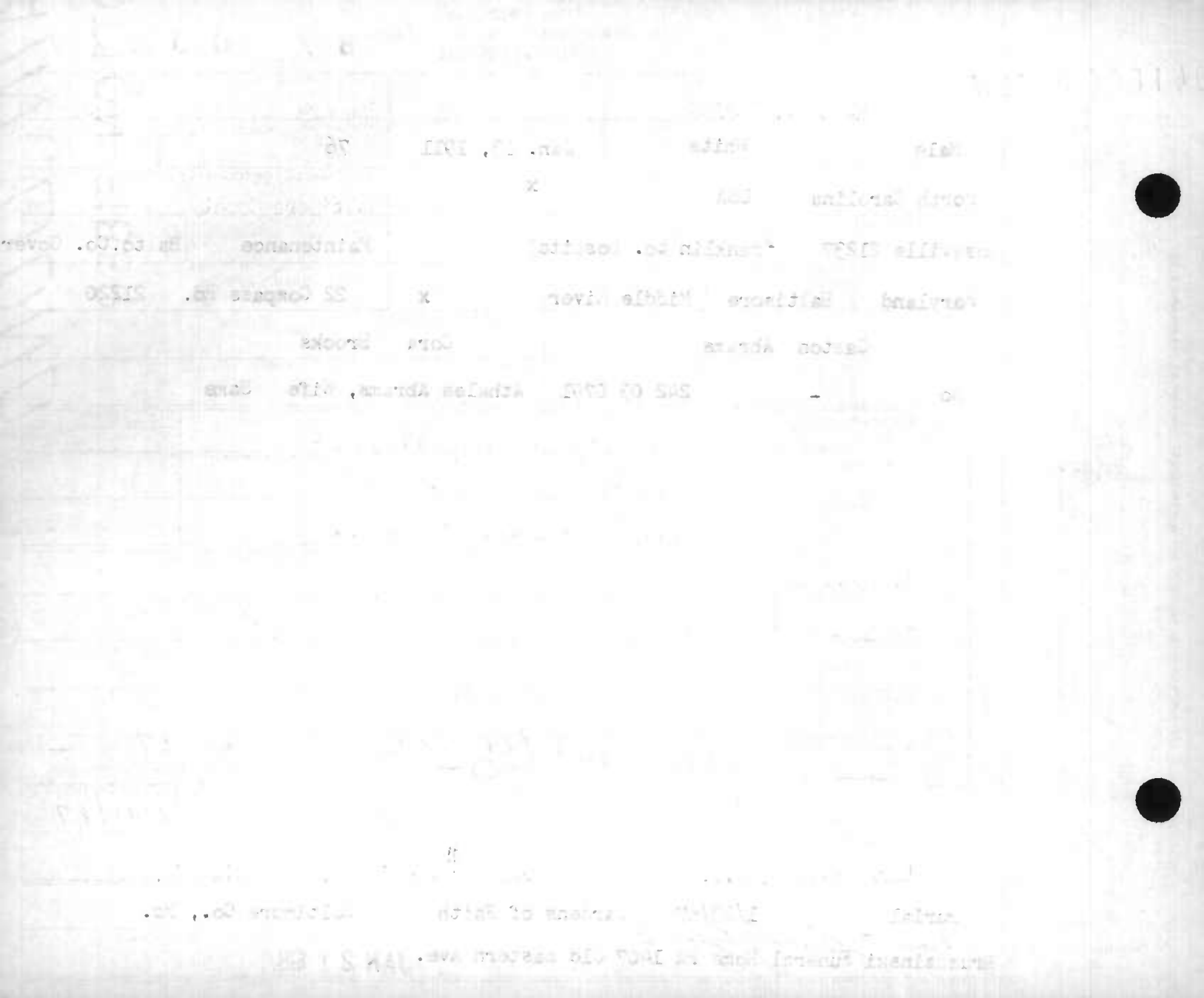
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 13 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 7 0 0 2 7 9 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Worth T. ABRAMS				2a. DATE OF DEATH MONTH DAY YEAR January 21, 1987				2b. HOUR 8:45a M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 13, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Rossville 21237		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Sq. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance		12b. KIND OF BUSINESS OR INDUSTRY Balto. Co. Gover	
13a. STATE Maryland		13b. CITY Baltimore		13c. CITY OR TOWN Middle River		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 22 Compass Rd. 21220	
14. FATHER'S NAME FIRST MIDDLE LAST Gaston Abrams				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Brooks					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT Athalee Abrams, Wife		ADDRESS Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Arrhythmia (cardiac) DUE TO, OR AS A CONSEQUENCE OF (c) Obstructive Lung Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Hypoxia.									
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) -					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1/14, 1987, to 1/20, 1987, that (I) (we) last saw the deceased alive on 1/20, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE Larry Wilson M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/21/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Larry Wilson, M.D.				22e. ADDRESS 3313 Papermill Rd., Phoenix, Md., 21131					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/23/87		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.			
24. FUNERAL DIRECTOR Bruzdzinski Funeral Home PA 1407 Old Eastern Ave.				25a. DATE REC'D. BY REGISTRAR JAN 21 1987		25b. REGISTRAR'S SIGNATURE			

BP. _____



41089 JAN 19 87

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STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR
 STATE
 REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Sally D. Adams				AKA: SALLIE D. ADAMS				2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH 1 DAY 13 YEAR 1987				2b. HOUR 5:34 PM			
1. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 1 DAY 25 YEAR 18		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YR. MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 		2c. DATE PRONOUNCED DEAD MONTH 1 DAY 13 YEAR 1987		2d. HOUR 5:34 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH BALTO COUNTY MD.			
10. CITY OR TOWN OF DEATH Arbutus				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1806 Winans Ave. 21227						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Receptionist				12b. KIND OF BUSINESS OR INDUSTRY Dental	
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. CITY Baltimore 13c. CITY OR TOWN Arbutus												13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1806 Winans Ave. 21227	
14. FATHER'S NAME FIRST St. Nicholas MIDDLE Daugerty LAST Sr.								15. MOTHER'S MAIDEN NAME FIRST Bessie MIDDLE Lee LAST 							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 216-01-9750				17. INFORMANT Harry L. Adams, Jr. ADDRESS 413 3rd Ave. 21227							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). EP, 12/85															
19a. DATE OF OPERATION 1/12/87				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>E. P. Williams Jr.</i>				TITLE (SPECIFY) M.D. Secretary				MEDICAL EXAMINER				DATE SIGNED 1/13/87			
EXAMINER'S NAME (TYPE OR PRINT) E. P. WILLIAMS JR.				ADDRESS 5550 BALTONAT LPK 21228											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/17/87				23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.				23d. LOCATION CITY OR TOWN Woodlawn COUNTY Baltimore STATE Md.			
24. FUNERAL DIRECTOR NAME Ambrose, Inc. ADDRESS 1328 Sulphur Spring Rd.				25a. DATE REC'D. BY REGISTRAR JAN 14 1987 25b. REGISTRAR'S SIGNATURE <i>Julia Benson-Randall</i>											

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PISTON ST., BALTIMORE, MD. 21201

 TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER'S OFFICE, WITH FORM PM-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PISTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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 DHMH - 17
 (VR A15 ME (5))

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W. H. H. H.



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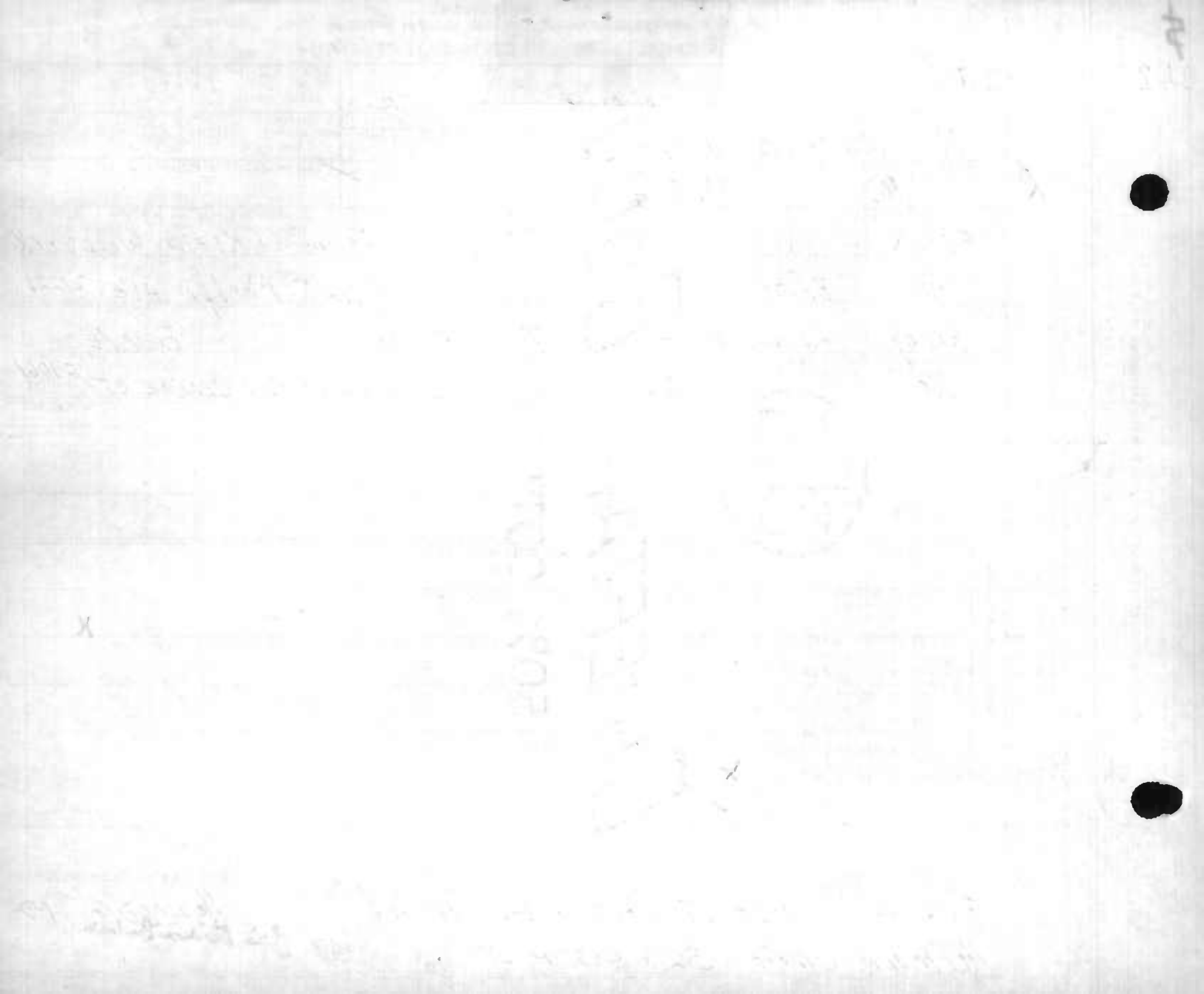
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE SPACE PROVIDED. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSFER OF REMAINS. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 00281	
1- STATE REGISTRAR											
2- DECEASED NAME (TYPE OR PRINT) HENRY			FIRST LAWRENCE			MIDDLE ADDICKS			LAST JR		
3- SEX M		4- RACE WHITE		5- DATE OF BIRTH MONTH 2 DAY 4 YEAR 1960		6- AGE (IN YEARS) (LAST BIRTHDAY) 36 YRS.		IF UNDER 1 YR. MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7- BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8- MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9- DATE KNOWN OF DEATH ESTIMATED 1 26 19 87		
10- CITY OR TOWN OF DEATH ESSEX			11- NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hosp. (DOA)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LEVINSON + KLEIN			12b. KIND OF BUSINESS OR INDUSTRY WOOD WORK		
13a. STATE MD.			13b. COUNTY BALTO.			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14- FATHER'S NAME FIRST HENRY MIDDLE LAWRENCE LAST ADDICKS SR.			15- MOTHER'S MAIDEN NAME FIRST ELOISE MIDDLE BURKE LAST 			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 216-54-6018		
17- INFORMANT ADDRESS ELOISE DANIELAN 934 GENIPE CT. 21061			18- CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Hypertrophic Cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) 			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20- AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles P. Kokes				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 1-26-87			
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.				ADDRESS 111 Penn St., Balto., MD 21201							
23a. BURIAL, CREMATION, REMOVAL (TYPE) BURIAL				23b. DATE 1-30-87				23c. NAME OF CEMETERY OR CREMATORY MEADOWKIDGE MEM PARK			
23d. LOCATION CITY OR TOWN HOWARD CO.				COUNTY MD.				STATE			
24- FUNERAL DIRECTOR NAME HOFFMANN-SHARDA				ADDRESS 3218 HUDSON ST				25b. DATE REC'D BY REGISTRAR JAN 30 1987			

07/84
25M

DHW-17
(VR A15 ME (5))



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 48, allows any injury, or other traumatic event, the medical examiner must be notified of such.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GOLDIE AISENBERG			2a. DATE OF DEATH MONTH DAY YEAR 11 16 87		2b. HOUR A M 10 A
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 1 11 1898	6. AGE (IN YEARS LAST BIRTHDAY) 89	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.		
10. CITY OR TOWN OF DEATH BALTO CALITY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, BALTIMORE COUNTY, OR ANNAPOLIS) 302 E. JOPPA RD., SUITE 908 HAMPTON PLAZA		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD	13b. COUNTY BALTO	13c. CITY OR TOWN TOWSON	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 302 E. JOPPA RD APT 908 #21204	
14. FATHER'S NAME FIRST MIDDLE LAST MAX NEISTADT	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BECKIE COHEN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		
16b. SOCIAL SECURITY NO. 278-48-7893		17. INFORMANT ADDRESS DR. ALVIN D. AISENBERG 614 MED. ARTS BLDG. 101 W. READ ST. #21201			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO! WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (his) hospital attended the deceased from Nov 19 1986 to Present , that (I) (we) lost saw the deceased alive on 11/15 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Petr Hitzig		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/16/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETR HITZIG, M.D.		22e. ADDRESS 302 E. JOPPA RD. TOWSON, MD 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE JAN. 18, 1987	23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO		23d. LOCATION CITY STATE COUNTY BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & B.O.S., INC.		24b. ADDRESS 6010 REISTERSTOWN RD. BALTO, MD 21215		25a. DATE REC'D. BY REGISTRAR JAN 28 1987	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

BP

1924

[Faint, illegible handwritten text and markings covering the majority of the page, possibly including a signature and various notes.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner's return. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 87 00283	
1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE CANICE LAST ALBERT				2a. DATE OF DEATH MONTH 1 DAY 15 YEAR 87 HOUR 8:57P	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 05 DAY 07 YEAR 15	
7a. BIRTHPLACE (COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Balto County MD	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST Joseph MIDDLE Erwin LAST Albert		15. MOTHER'S MAIDEN NAME FIRST Regina MIDDLE L. LAST Becker		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-78-6512		17. INFORMANT ADDRESS Sr. M.A. Catina SSND 6401 N. Chas. St. 21212	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR TACHYCARDIA DUE TO, OR AS A CONSEQUENCE OF (b) CARDIOGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF (c) ANTERIOR WALL MI				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Rivera</i>		DEGREE		22c. DAYS SIGNED 1/12/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RIVERA		22e. ADDRESS 54 Scott Adam Road X			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-19-87		23c. NAME OF CEMETERY OR CREMATORY Villa Maria	
23d. LOCATION CITY OR TOWN Glen Arm		COUNTY Balto.		STATE Md.	
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home 6500 York Road 21212		25a. DATE REC'D. BY REGISTRAR JAN 20 1987		25b. REGISTRAR'S SIGNATURE <i>Lia Davidson-Randall</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place in the container papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. **IMPORTANT:** If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 87 00284			
1. DECEASED NAME (TYPE OR PRINT) W. SPAULDING ALBERT				2a. DATE OF DEATH MONTH DAY YEAR JANUARY 22, 1987			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 11, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE County MD	
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Executive		12b. KIND OF BUSINESS OR INDUSTRY A.S. Abell	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE MD		13b. COUNTY Balto.		13c. CITY OR TOWN Towson		13d. STREET ADDRESS / ZIP CODE 2300 Dulany Valley Rd., 21204	
14. FATHER'S NAME FIRST MIDDLE LAST Albert Spaulding				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Theresa			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 213 03 2615		17. INFORMANT ADDRESS Melvin Goetze, Lutherville, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) intractable asystole DUE TO, OR AS A CONSEQUENCE OF: (b) prob acute MI DUE TO, OR AS A CONSEQUENCE OF: (c) severe CAD APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Hitral reoperation prior silent MI							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from 1/22 19 86 , to 1/22 19 87 , that (2) (we) lost saw the deceased alive on 1/22 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)							
22b. SIGNATURE D. Anton, MD DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/22/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. Anton, MD				22e. ADDRESS St. Joseph's Hospital, Balto., MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/24/87		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, MD	
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co.				25a. DATE REC'D BY REGISTRAR JAN 28 1987			
4905 York Road Balto., MD 21212				25b. REGISTRAR'S SIGNATURE Julia J. ...			

BP

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400 York Road, Baltimore, MD 21215

Franklin D. Roosevelt Library

1941

Project: Roosevelt

File 111

MD

1. January 1941

2. January 1941, Baltimore, MD

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Item # 236, Film G 624, 2/4/87 ra

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

00285

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MAURICE A. ALLEN SR.			2a. DATE OF DEATH MONTH DAY YEAR 1-4-87			2b. HOUR 2:49 PM	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 01 16 1919		6. AGE (IN YEARS (LAST BIRTHDAY)) 67 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CO., MARYLAND MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE CO. GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FORK LIFT OPERATOR MD. GLASS	
13a. STATE MARYLAND				13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM O. ALLEN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VIRGINIA NICHOLSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 237-034166		17. INFORMANT Mrs. Baltimore, Maryland Rosena Allen 3206 Garrison Blvd. 21216	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE Bilateral pulmonary Embolism DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: LEFT LUNG MASS; URINARY TRACT INFECTION							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 1-4-87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. 87							
22b. SIGNATURE 		22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22d. DATE SIGNED 1-4-87	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) ORLANDO B. CONWAY, MD		22f. ADDRESS 2064 RANDOLPH ST. MD. 21133					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/09/1987		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Veteran		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR OF NAME ADDRESS NOTHER & SONS FUNERAL HOME, INC. 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216				25a. DATE REC'D. BY REGISTRAR JAN 6 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

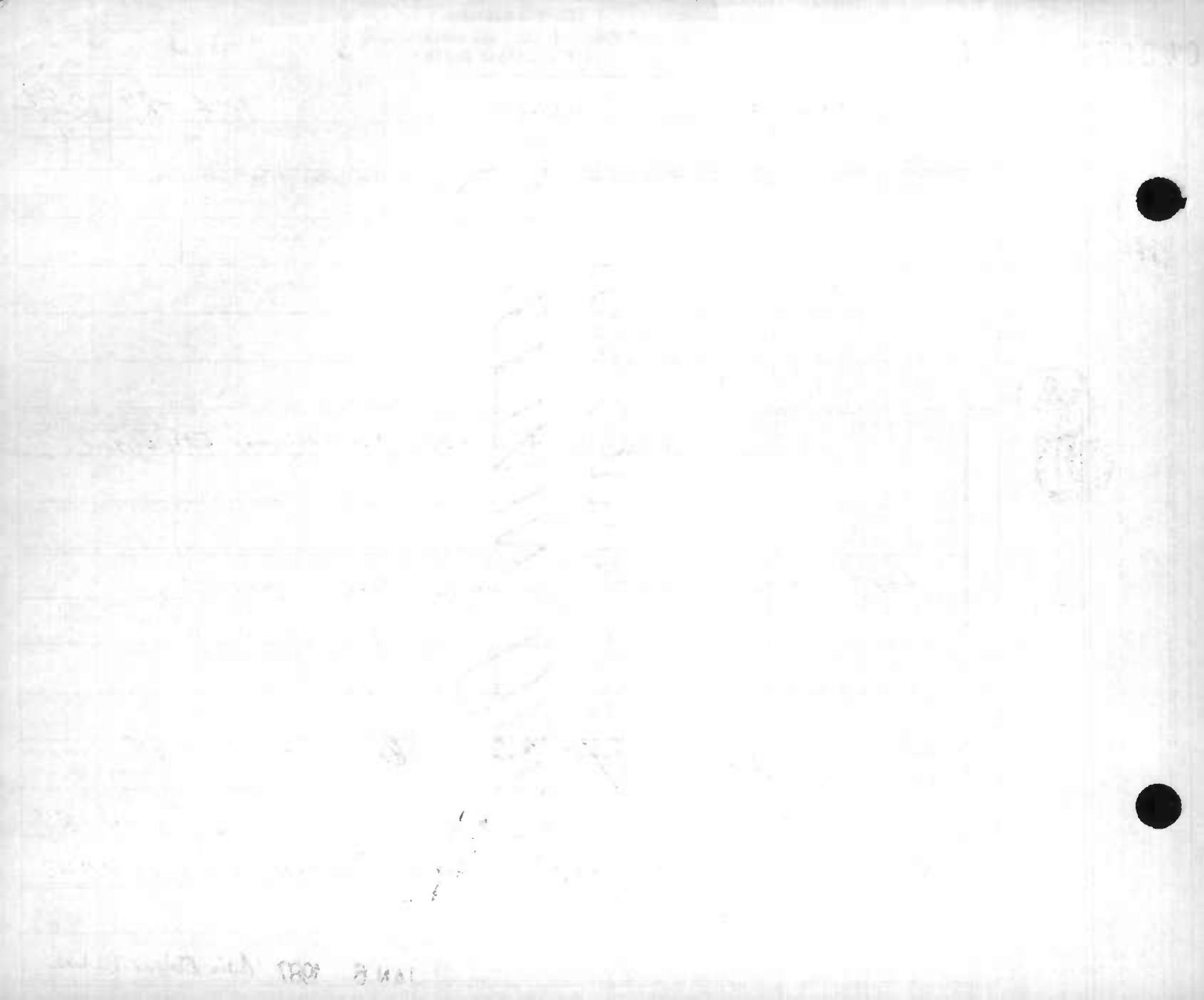
MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove containing pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. A medical examiner must be notified before burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, it must be examined by a medical examiner.

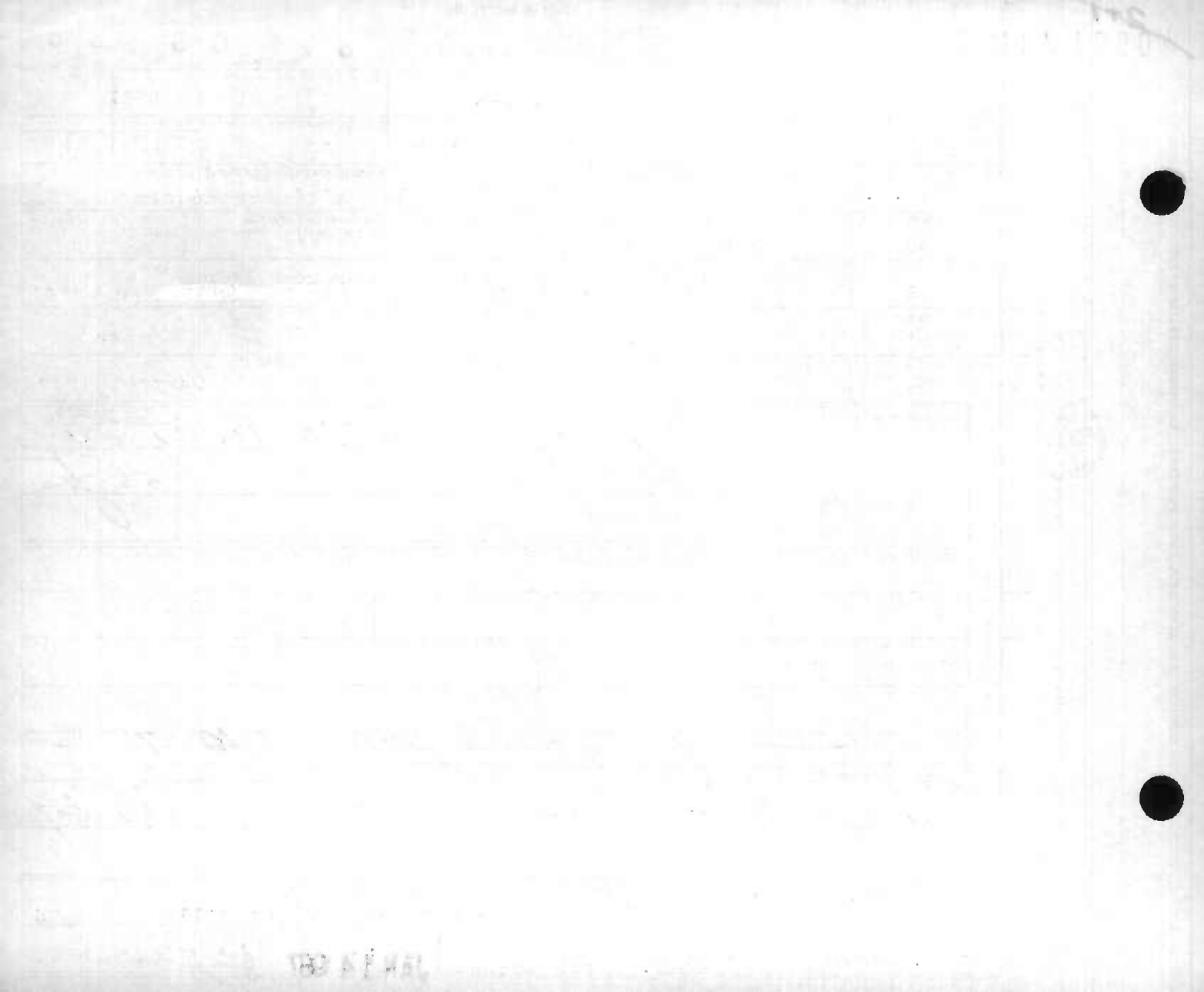


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert in the envelope. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 00280	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Romie Allison						2a. DATE OF DEATH MONTH DAY YEAR 1 10 1987				2b. HOUR M	
3. SEX male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10 5 1909		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore county MD.					
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dulaney Tower N/H				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Baker			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md						13b. COUNTY V		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Sandy Allison						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Sampson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-07-3036		17. INFORMANT ADDRESS Virginia Newman 2632 Garrett Avenue							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac-Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>5+ yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>5+ yrs</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>8/17/84</u> , to <u>1/10/87</u> , that (I) <u>(saw)</u> saw the deceased alive on <u>1/10/87</u> , and that in (my) <u>(own)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did not)</u> view the body after death.											
22b. SIGNATURE <u>Robert H. [Signature]</u>						22c. DATE SIGNED <u>1/13/87</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) 22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/14/87		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Vet		23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills Md			
24. FUNERAL DIRECTOR NAME Wm C. March F/H 1101 E. North Avenue						25a. DATE REC'D. BY REGISTRAR JAN 14 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement for death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The certificate remains carbon papers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
<div style="display: flex; justify-content: space-between;"> <div> 1. FOR STATE REGISTRAR 42808 FEB - 3 87 </div> <div> REG. NO. 87 00287 </div> </div>									
1. DECEASED NAME (TYPE OR PRINT) PAUL Eder ALVEY					2a. DATE OF DEATH 1/30/87 03-10-06			2b. HOUR 8:55 AM	
3. SEX M		4. RACE CAUCASIAN		5. DATE OF BIRTH 03 10 '06		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. MD.			
10. CITY OR TOWN OF DEATH BALTO COUNTY Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTO. COUNTY GEN'L HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY Rail Road	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md. 13b. CITY OR TOWN: Carroll Finksburg					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE 21048 Part 2 Lot 78 Hillendale Park		
14. FATHER'S NAME FIRST: Robert CLinton MIDDLE: ALvey					15. MOTHER'S MAIDEN NAME FIRST: Nellie MIDDLE: Margaret LAST: Eder				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 705-05-4902		17. INFORMANT ADDRESS 18 Scott St Pativcia Gerbvick Hanover, PA. 17331					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Possible cerebrovascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis, Hypertensive Heart Disease</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Ruptured Abdominal Aortic Aneurysm</u>									
19a. DATE OF OPERATION 1/17/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ruptured abd. aortic Aneurysm</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1/17</u> , 19 <u>87</u> , to <u>1/30</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>1/30</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>				DEGREE		22c. DATE SIGNED 1/30/87		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. TRADHAN				22e. ADDRESS 122 SLADE AVE BALTO MD 21208					
23a. BURIAL, CREMATION, REMOVAL (LIFE) <u>Burial</u>		23b. DATE Feb. 3, 1987		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md			
24. FUNERAL DIRECTOR NAME: <u>Anthony E. Schmitt</u> ADDRESS: <u>Manchester, Md.</u>				25a. DATE REC'D. BY REGISTRAR FEB - 2 1987					

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042237 JAN 19

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 00288

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Anna Ament			2a. DATE OF DEATH MONTH DAY YEAR 1 24 87		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 9, 1905		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 82	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Edgemere	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2918 Ritchie Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Edgemere	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Repasch			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Theresa Hutter		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-46-5205		17. INFORMANT ADDRESS George H. Ament 2918 Ritchie Ave. 21219	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cancer of Breast</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cancer of Breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>5 years</u>
19a. DATE OF OPERATION 1982		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer of Breast		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22. I certify that (I) (the hospital) attended the deceased from <u>Jan 50</u> to <u>Jan 24</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>Jan 24</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Roger Windsor</u>		DEGREE MD		22c. DATE SIGNED 1.26.87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roger Windsor M.D.		22e. ADDRESS 10120 Rd No 6 Unit Rd, Seat Rd 21224			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-17-87		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		24. FUNERAL DIRECTOR NAME ADDRESS 7922 Wise Ave. 21222 Duda-Ruck Funeral Home, Inc. Dundalk, Md.			
25a. DATE REC'D. BY REGISTRAR JAN 28 1987		25b. REGISTRAR'S SIGNATURE <u>Gula Davidson-Randall</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The certificate must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 0 0 2 8 9

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE LOUISE LAST AMOS			2a. DATE OF DEATH MONTH DAY YEAR 01 15 87		2b. HOUR 10:45 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 18, 1933		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.		10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC-6701 N CHARLES ST.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY ---		13a. STREET ADDRESS / ZIP CODE 10929 Red Lion Road 21162	
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN White Marsh	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST Archer MIDDLE Andrew LAST Alexander			15. MOTHER'S MAIDEN NAME FIRST Louise MIDDLE Josephine LAST Magness		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --		17. INFORMANT ADDRESS Joppa, Md. 21085 Katherine A. Baummer, 306 Magnolia Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC COLON CANCER DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22. I certify that (I) (this hospital) attended the deceased from 01/15, 19 87, to 01/15, 19 87, that (I) (we) lost saw the deceased alive on 01/15, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22a. SIGNATURE J. Sterrette		DEGREE		22b. DATE SIGNED 1/16/87	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) J. STERRETTE, MD		22d. ADDRESS GBMC-6701 N. CHARLES ST.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 19, 1987		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Mem. Gardens	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Md.		23e. DATE REC'D. BY REGISTRAR JAN 20 1987			
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009		25b. REGISTRAR'S SIGNATURE Julia Benson-Randall			

BP

041805 JAN 27 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 000290

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Frank G. Amthor			2a. DATE OF DEATH MONTH DAY YEAR 1-21-87		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 8-30-1901		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD		
10. CITY OR TOWN OF DEATH Rossville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care - Rossville		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chemical Engineer	12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Balto.	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE 5000 Eugene Avenue-21206	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 140-10-0368	17. INFORMANT ADDRESS Eleanor S. Amthor - 5000 Eugene Ave.-21206			
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Dementia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Mohammed N. Khan MD</u>		DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MOHAMMED N. KHAN		22e. ADDRESS 5601 - Loch Raven Blvd, Balto, 21239			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment	23b. DATE 1-23-87	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.		
24. FUNERAL DIRECTOR NAME John C. Miller, Inc. -6415 Belair Rd.-21206		25a. DATE REC'D. BY REGISTRAR JAN 23 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Gordon-Randall</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

50% COTTON 20% WOOL

MADE IN U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top papers. Page 1 and 2 should be filed with the 24 hours after death. IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				87		00291	
REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>ELSIE B. Anderson</i>				2a. DATE OF DEATH MONTH DAY YEAR 01 16 87		2b. HOUR 9:45 P M	
3 SEX Female		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 07 13 03		6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH PARKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridan Nursing / Perring Parkway		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b. KIND OF BUSINESS OR INDUSTRY DRUG LAB.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE	
14 FATHER'S NAME FIRST MIDDLE LAST William C. BRYANS		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Marie HELWIG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2905 KIRK AVE. 21218	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217031625		17 INFORMANT FAMILY RECORDS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov 19 85</i> to <i>Jan 19 87</i> that (I) (we) last saw the deceased alive on <i>12/87</i> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>1/19/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Chesnut</i>		22e. ADDRESS <i>5218 Spangler Way</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1-19-1987		23c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE Maryland	
24 FUNERAL DIRECTOR NAME EVANS CHAPEL OF MEMORIES HARFORD		ADDRESS 8800 ROAD		25a. DATE REC'D. BY REGISTRAR JAN 19 1987		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

[Faint, mostly illegible text covering the page, possibly bleed-through from the reverse side. Some words like "E", "X", "H", "A", "B", "C", "D", "E", "F", "G", "H", "I", "J", "K", "L", "M", "N", "O", "P", "Q", "R", "S", "T", "U", "V", "W", "X", "Y", "Z" are visible.]

21

040633 JAN 14

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 00292

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Anthony		FIRST Anthony		MIDDLE Ariko		LAST Ariko		2a. DATE OF DEATH MONTH DAY YEAR 1 8 87		2b. HOUR 1:45 A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 28 1913		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, County MD.					
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 106 Kenilworth Park Dr. 21204						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales		12b. KIND OF BUSINESS OR INDUSTRY Retail	
13a. STATE Maryland		13b. COUNTY Balto.		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 106 Kenilworth Park Dr. 21204			
14. FATHER'S NAME FIRST MIDDLE LAST Michael Ariko				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Bunn							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.11		17. INFORMANT Mrs. Dorothy Ariko		ADDRESS Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Lung Cancer										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mon.	
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from Oct 12/86 to Jan 8 1987 , that (2) we last saw the deceased alive on 12/18/86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (3) we (did) (did not) view the body after death.											
22b. SIGNATURE Charles A. Padgett						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/8/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles A. Padgett M.D.						22e. ADDRESS 5601 Loch Raven Blvd. 21239					
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Entombment		23b. DATE 1/10/87		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Timonin Balto. Md.					
24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. 21204						25a. DATE REC'D. BY REGISTRAR JAN 12 1987		25b. REGISTRAR'S SIGNATURE Julia Sanders-Randall			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon plates. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic condition, medical examiner must be notified at once.

3

041092 JAN 19 1987

FOR
STATE
REGISTRAR

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

00293

1 DECEASED NAME (TYPE OR PRINT)			FIRST Marie			MIDDLE G.			LAST Armstrong			7a. DATE KNOWN OF ESTI- MATED			7b. DATE MONTH DAY YEAR			7c. DATE PRONOUNCED DEAD			7d. HOUR		
3 SEX Female			4 RACE White			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS) LAST (MONTH DAY) YRS.			IF UNDER 1 YR. MONTHS DAYS HOURS MIN.			7e. DATE MONTH DAY YEAR			7d. HOUR					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH														
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY														
Anneslie			Armacost Nursing Home			Worker			Cafeteria														
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS											
Maryland			Balto.			Timonium			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			40 Gorsuch Rd. 21093											
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST																				
Unknown			Grachova			Unknown			Unknown														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS																	
No			213-14-0700			Marie A. Karl - same as #13e																	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: 8809 IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <u>fractured RT ankle</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>HSCVD</u>																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>29 Days</u> <u>5 1/2 yrs</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
19a. DATE OF OPERATION <u>12/12/86</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u>Ankle Casted No Oper</u>															20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>PM Dec 12 1987</u>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>Fall down stairs</u>																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>Home</u>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>40 Gorsuch Rd Timonium Balto Md</u>																	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>												TITLE (SPECIFY) <u>Deputy</u>		MEDICAL EXAMINER				DATE SIGNED <u>1/10/87</u>					
EXAMINER'S NAME (TYPE OR PRINT)			Charles F. O'Donnell, M.D. ADDRESS 7501 York Rd., Towson, Md. 21204																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN			COUNTY			STATE								
Burial			1-13-87			Dulaney Valley			Timonium			Balto.			Md.								
24 FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D BY REGISTRAR			REGISTRAR'S SIGNATURE														
Rick Towson Funeral Home, Inc.			Towson, Md. 21204			JAN 14 1987			<u>Julia Scivron-Rudick</u>														

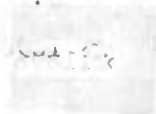
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN BLOCK IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/82

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the Department of Health and Mental Hygiene prior to burial or cremation.

IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

042974 FEB 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
"DEPARTMENT OF HEALTH AND MENTAL HYGIENE"
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Helen ATKINSON			2a. DATE OF DEATH MONTH DAY YEAR January 24, 1987			2b. HOUR 4:17 a.m.			
3 SEX FEMALE		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR 12 27 1907		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) UNIONTOWN, PA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH ROSEDALE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND			13b. CITY OR TOWN BALTIMORE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1430 DUNDALK AVENUE 21224		
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES CONWAY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JINNY DONAHUE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 211-07-9483		17. INFORMANT ADDRESS SHELDON DIGGINS, ATTY. 6903 DUNMAN WAY 21222				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Pulmonary Embolism DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 20, 1987 , to January 24, 1987 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on January 24, 1987 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.									
22b. SIGNATURE Sarah L. Owens			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-24-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sarah L. Owens, M.D.			22e. ADDRESS 9000 Franklin Square Dr. 21237						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-27-87		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.		
24. FUNERAL DIRECTOR NAME Walter Dabrowski			ADDRESS 1005 Dundalk Avenue 21224			25. DATE REC'D. BY REGISTRAR JAN 28 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Maria E. Auteri

2. DATE OF DEATH MONTH DAY YEAR
1.8.87 5:45 P.M.

3. SEX *Female* 4. RACE *White* 5. DATE OF BIRTH MONTH DAY YEAR
1 6 1897

6. AGE (IN YEARS LAST BIRTHDAY) *90* YRS IF UNDER 1 YEAR IF UNDER 24 HRS
MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) *Sicily* 7b. CITIZEN OF WHAT COUNTRY? *Italy* 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH *Balto. County* MD.

10. CITY OR TOWN OF DEATH *Towson Md* 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) *Stella Maris Hospice 2300 Delaney Valley Rd 21204*

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) *Seamstress Ret.* 12b. KIND OF BUSINESS OR INDUSTRY *Clothing*

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE *Md.* 13c. CITY OR TOWN *Baltimore* 13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE *2909 Alvarado Sq 21234*

14. FATHER'S NAME FIRST MIDDLE LAST *Signarino Auteri* 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST *Filomena Salerno*

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) *No* 16b. SOCIAL SECURITY NO. *212-03-9250* 17. INFORMANT ADDRESS *Nunzio Auteri 2909 Alvarado Square 21234*

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) *Adenocarcinoma of Stomach*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 19c. AUTOPSY? YES ☐ NO ☐ 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 P.M. 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21a. INJURY OCCURRED 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21c. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from *12-29 1986* to *1.8 1987*, that (I) ☒ saw the deceased alive on *1.8 1987*, and that in (my) ☒ opinion death occurred on the date and hour and from the causes stated above, (I) ☒ did (did not) view the body after death.

22b. SIGNATURE *Eddie Nakhuda* DEGREE 22c. DATE SIGNED *1.8.87*

22d. PHYSICIAN'S NAME (TYPE OR PRINT) *Eddie Nakhuda, M.D.* 22e. ADDRESS *Stella Maris Hospice Dulaney Valley Rd.-Towson, MD 21204*

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) *Burial* 23b. DATE *Jan 12 1987* 23c. NAME OF CEMETERY OR CREMATORY *Most Holy Redeemer* 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Maryland

24. FUNERAL DIRECTOR NAME ADDRESS *Leonard J. Ruck, Inc. Baltimore, Maryland* 25a. DATE REC'D. BY REGISTRAR *JAN 12 1987* 25b. REGISTRAR'S SIGNATURE *Julia Tindon-Rudolph*



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ethel Gertrude Bading			2a. DATE OF DEATH MONTH DAY YEAR January 7 1987			2b. HOUR 2:50 AM		
3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR August 18 1904		
6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.			7. IF UNDER 1 YEAR MONTHS DAYS 0 0			7b. IF UNDER 24 HRS HOURS MIN. 0 0		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			10. CITY OR TOWN OF DEATH Randallstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Randallstown		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 3604 N. Chapman Rd. 21133					
14. FATHER'S NAME FIRST MIDDLE LAST Howard Young			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosalie Tarr					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217-07-3270D6			17. INFORMANT NAME ADDRESS Mr. Howard Bading 21157 74 Westchester Ave. Westminster Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Bacteria, UTI								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) (1) D.M. (2) IHD. (3) INANITION								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from 01/04/87 to 01/07/87 , that (1) (we) last saw the deceased alive on 01/07/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Dr. Deepak Merchant			DEGREE MD			22c. DATE SIGNED 01/07/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Deepak Merchant			22e. ADDRESS Baltimore County General Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-10-87			23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown Baltimore MD								
24. FUNERAL DIRECTOR NAME ADDRESS Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133						25a. DATE REC'D. BY REGISTRAR JAN 13 1987		
25b. REGISTRAR'S SIGNATURE Julia Bading								

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18, there is no injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

040804

General Building

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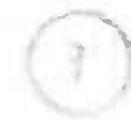
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

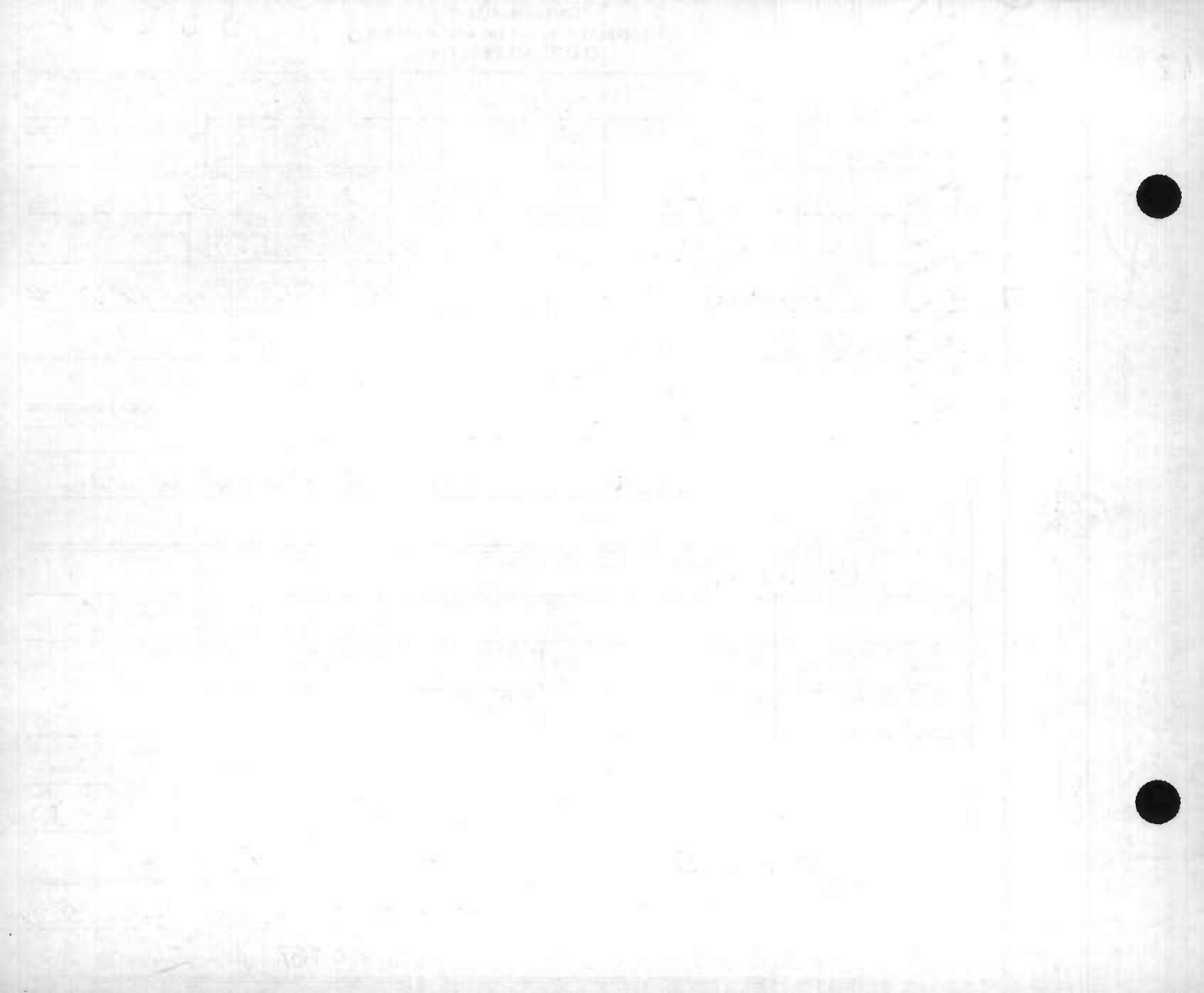
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. The certificate for coroners appears. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, the attending physician must complete the medical examiner's certificate on the attached page.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					REG. NO.	
1- STATE REGISTRAR			42299 JAN 28 1987		00291	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR	
MYRTLE - BAGLEY					JAN. 24, 1987	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)
FEMALE		WHITE		FEB. 09, 1901		85
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH
PENN.		U.S.A.				BALTO. CO. MD.
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
PERRY HALL		9418 BELLHALL DR. 21236		HOUSEWIFE		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS / ZIP CODE
MD.		BALTO. CO.		PERRY HALL		9418 BELLHALL DR. 21236
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
CHARLES FRYE			UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
NO		216-07-3324		FAMILY RECORDS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarct.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ischemic Heart disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Reperfusion.</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Reperfusion.</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Patricio</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>1/28/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DR. PATRICIO</u>				22e. ADDRESS <u>2926 E. COLD SPRING LA.</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>1-27-1987</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MAYS CHAPEL CEM.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>TYMONIUM BALTO. CO. MD.</u>
24. FUNERAL DIRECTOR <u>EVANS CHAPEL OF MEMORIES</u>				25a. DATE REC'D. BY REGISTRAR <u>JAN 28 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Landack</u>

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and place them in the box provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) CHARLOTTE M. BAILEY				2a. DATE OF DEATH MONTH DAY YEAR Jan. 25, 87				2b. HOUR 12:20 P			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 08 11 08		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		IF UNDER 1 YEAR MONTHS DAYS 00 00		IF UNDER 24 HRS HOURS MIN. 00 00	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY --		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3939 Roland Ave. 21211			
14. FATHER'S NAME FIRST MIDDLE LAST Christian G. Woppman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Malloy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No --				16b. SOCIAL SECURITY NO. 219-18-2115		17. INFORMANT ADDRESS Mary Jane Pahl 4211 Buckingham Rd. 21207					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac arrhythmia and arrest DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) 											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Jan. 23, 1987 to Jan. 25, 1987 , that (I) (we) last saw the deceased alive on Jan. 25, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Shassem Pourmotabar				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-25-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHASSEM POURMOTABAR				22e. ADDRESS Balto. Co. General Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/29/87		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS A. Alan Seitz Funeral Home 3818 Roland Ave.				25a. DATE REC'D. BY REGISTRAR JAN 27 1987		25b. REGISTRAR'S SIGNATURE [Signature]					



The following text is a transcription of the handwritten notes on the page. The text is written in a cursive script and is somewhat difficult to read due to the handwriting and the quality of the scan. The text appears to be a list of items or a description of a process.

1. The first item is a description of a component or a part of a machine. It is described as a rectangular object with a diagonal line and a small square at the bottom left corner. The text is written in a cursive script and is somewhat difficult to read due to the handwriting and the quality of the scan.

2. The second item is a description of a component or a part of a machine. It is described as a rectangular object with a diagonal line and a small square at the bottom left corner. The text is written in a cursive script and is somewhat difficult to read due to the handwriting and the quality of the scan.

3. The third item is a description of a component or a part of a machine. It is described as a rectangular object with a diagonal line and a small square at the bottom left corner. The text is written in a cursive script and is somewhat difficult to read due to the handwriting and the quality of the scan.

4. The fourth item is a description of a component or a part of a machine. It is described as a rectangular object with a diagonal line and a small square at the bottom left corner. The text is written in a cursive script and is somewhat difficult to read due to the handwriting and the quality of the scan.

5. The fifth item is a description of a component or a part of a machine. It is described as a rectangular object with a diagonal line and a small square at the bottom left corner. The text is written in a cursive script and is somewhat difficult to read due to the handwriting and the quality of the scan.

6. The sixth item is a description of a component or a part of a machine. It is described as a rectangular object with a diagonal line and a small square at the bottom left corner. The text is written in a cursive script and is somewhat difficult to read due to the handwriting and the quality of the scan.

7. The seventh item is a description of a component or a part of a machine. It is described as a rectangular object with a diagonal line and a small square at the bottom left corner. The text is written in a cursive script and is somewhat difficult to read due to the handwriting and the quality of the scan.

8. The eighth item is a description of a component or a part of a machine. It is described as a rectangular object with a diagonal line and a small square at the bottom left corner. The text is written in a cursive script and is somewhat difficult to read due to the handwriting and the quality of the scan.

9. The ninth item is a description of a component or a part of a machine. It is described as a rectangular object with a diagonal line and a small square at the bottom left corner. The text is written in a cursive script and is somewhat difficult to read due to the handwriting and the quality of the scan.

10. The tenth item is a description of a component or a part of a machine. It is described as a rectangular object with a diagonal line and a small square at the bottom left corner. The text is written in a cursive script and is somewhat difficult to read due to the handwriting and the quality of the scan.

042290 JAN 28 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. Then please forward it to the funeral home. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
FOR 1. STATE REGISTRAR					REG. NO. 7 00299					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carolyn Rose BAKER					2a. DATE OF DEATH MONTH DAY YEAR January 21, 1987			2b. HOUR 1:10 PM		
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 11 01 35		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK, MOST OF WORKING LIFE) CLERK		12b. KIND OF BUSINESS OR INDUSTRY MANUFACTURING		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND					13b. CITY OR TOWN BALTIMORE		13c. CITY OR TOWN ROSEDALE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST GABRIEL					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SOPHIA PETRILIK					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. 217-30-2914		17. INFORMANT ADDRESS PAUL BAKER 5344 KING ARTHUR CIRCLE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Coma, Anoxic Encephalopathy DUE TO, OR AS A CONSEQUENCE OF (c) Cardio Pulmonary Arrest (Resuscitated) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Pneumonia, Cirrhosis of Liver, Alcoholism										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from December 20, 1986 to January 21, 1987 that (I) (we) lost saw the deceased alive on January 21, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Nacam Gauhar</i>					DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1/21/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nacam Gauhar M.D.					22e. ADDRESS 9000 Franklin Square Drive					
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 01/24/87		23c. NAME OF CEMETERY OR CREMATORY FAITH		23d. LOCATION BALTO. BALTO. MD.				
24. FUNERAL DIRECTOR <i>Jeffrey</i> (211) <i>Chesapeake</i>					25a. DATE REC'D. BY REGISTRAR JAN 28 1987					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 4 and 5, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Willis C. Baker				Jan. 15, 1987		7:16 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Male		White		Nov. 3, 1907		79 YRS.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
New York		USA				Baltimore County MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Catonsville		Summitt Nursing Home		Retired		Self employed			
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.		Howard Ellicott		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8614 Chapel View		21043	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Glenn Baker		Mabel Fulcher		No		095-10-5398		Mrs. Richard Martin	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
IMMEDIATE CAUSE (a) Cardiac arrest						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
History of cardiovascular accident									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9-10-86 to 1-15-87, that (we) lost saw the deceased alive on 1-20-86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED					
Raafat Z. Girgis		1-15-87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Raafat Y. Girgis		500 N. Rolling Rd. Catonsville - MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		Jan. 19'87		Memorial Park		St Petersburg Florida			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Harry H Witzke & Family Funeral Home Inc 4412 4112 Old Columbia Pike Ellicott City		JAN 16 1987		Julia Anderson					

BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR			
JAMES Oliver		BALDERSON						1/2/87								1:56 PM			
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)				7. IF UNDER 1 YEAR				8. IF UNDER 24 HRS.			
Male		White		March 17, 1943				43 YRS.				MONTHS				DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland		USA						Baltimore Co. MD.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Towson		St. Joseph Hospital								Plant Foreman				Gen Star					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE											
Maryland		Baltimore		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21230 139 E. West St. Balto. Md.											
14. FATHER'S NAME								15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST Wilbur John Balderson, Sr.								FIRST MIDDLE LAST Bessie Elizabeth Scott											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS											
No				219-40-1198				21061 Glen Burnie, Md. Wilbur J. Balderson, Jr. 33 Chester Circle											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																			
PART 1. DEATH WAS CAUSED BY																			
IMMEDIATE CAUSE (a) CARDIAC ARREST U. FIB																			
DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL REPERFUSATION 28 hours																			
DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
1-1-87 1-2-87				Cardiac Arrest				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
				HOUR A.M. MONTH DAY YEAR P.M. 19															
21d. INJURY OCCURRED				21e. PLACE OF INJURY				21f. LOCATION											
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from 1-1-87, 1987, to 1-2-87, 1987, that (I) (we) lost saw the deceased alive on 1-2-87, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE												22c. DATE SIGNED							
G.R. McDonald												FACES							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)												22e. ADDRESS							
DR. G.R. McDonald												ST JOSEPH Hosp. P.A.C.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION									
Burial				Jan. 6, 1987		Cedar Hill Cemt.				Balto. A.A. Co. Maryland									
24. FUNERAL DIRECTOR												25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
NAME Balto. Md. 21230 McCully Funeral Home 130 E. Fort Ave.												JAN 5 1987				John D. ...			

[Faint, illegible text throughout the page, likely bleed-through from the reverse side.]

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040385 JAN 1987

Item # 2a & 22a, Film G 624, 2/24/87 ra

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 00302

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mary Virginia Smith Baldwin			2a. DATE OF DEATH MONTH DAY YEAR Jan. 5 1987		2b. HOUR 6:55 M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 12 1895		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Multi Purpose Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Balto. County Dog Catcher Dept.	
13a. STATE Maryland				13b. COUNTY BALTO		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST John W. Smith				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Louise Curry			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS Mary B. Price, 7 Glenellen Ct., 21204			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) CVA DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 HRS 4 months 20 YRS						PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, HISTORY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1978 19 to 1/5/87 19			
22. I certify that (1) this hospital attended the deceased from 1/5/87 to 1/5/87 that (2) I well and saw the deceased alive on 1/5/87 and that in my (our) opinion death occurred on the date and hour and from the causes stated. (I/we did/did not) see the body after death.							
22a. SIGNATURE Paul Edgar, M.D.				22b. ADDRESS 660 Kenilworth Dr., 21204		22c. DATE SIGNED 1/7/87	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/8/87		23c. NAME OF CEMETERY OR CREMATORY Chestnut Grove Pres.		23d. LOCATION CITY OR TOWN COUNTY STATE Phoenix Balto. Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Martin D. Lawson, 10 W. Padonia Rd., 21093				25a. DATE REC'D. BY REGISTRAR JAN 8 1987		25b. REGISTRAR'S SIGNATURE John F. ...	

IMPORTANT: If item 21 is marked as item 18 shows only injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP



Handwritten signature or text at the bottom right.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

3-040628 JAN 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate and page 4 to the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE												8700303							
FOR 1- STATE REGISTRAR												REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) ETHEL H. BANKARD						2a. DATE OF DEATH MONTH DAY YEAR 1/7/86				2b. HOUR 2:55 AM									
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2/1/1888		6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 72 HRS HOURS MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.													
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pickersgill				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY C. & P. Telephone											
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY Baltimore 13c. CITY OR TOWN Towson						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Pickersgill Chestnut Ave 21204											
14. FATHER'S NAME FIRST MIDDLE LAST William C. Henderson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Young															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No X				16b. SOCIAL SECURITY NO 217-05-2007		17. INFORMANT Pickersgill, Inc.		ADDRESS 615 Chestnut Ave Towson, Md. 21204											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Cholesterol Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 days 20 yrs							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from June 1981 , to 1-6-1987 , that (I) (we) last saw the deceased alive on 1-5-87 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE Manley M.D.						DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1-7-87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Keith Manley, M.D.						22e. ADDRESS Pot Spring Rd., Timonium, Md. 21093													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1-9-87		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.											
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204						ADDRESS 1050 York Rd.		25a. DATE REC'D. BY REGISTRAR JAN 12 1987		25b. REGISTRAR'S SIGNATURE Julia Division-Rudner									

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JAN 1 1961

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return completed pages 1, 2 and 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked, item 18 and every injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
ALICE DRAPER BANKERT					1 22 87 2:00 AM				
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH JUNE 27, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7b. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CO. MD			
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE CO. GENERAL HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPERVISOR		12b. KIND OF BUSINESS OR INDUSTRY 1300K WESTMINSTER, MD	
13a. STATE MARYLAND		13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 116 HIGHLAND RD 21157	
14. FATHER'S NAME FIRST MIDDLE LAST RICHARD DRAPER					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH (UNKNOWN MAIDEN)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N. A.		17. INFORMANT ADDRESS MR. LAURENCE BANKERT 116 HIGHLAND RD WESTMINSTER, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OAT cell CA of lung: DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 21, 19 87, to 1-22, 19 87, that (I) (we) last saw the deceased alive on 1-22, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Rajendra Govinda					DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-22-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAJENDRA GOVINDA RA, MD					22e. ADDRESS BALT. COUNTY GEN. HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE JAN 23, 1987		23c. NAME OF CEMETERY OR CREMATORY CARROLL CREMATORY		23d. LOCATION HAMPSTEAD CITY OR TOWN COUNTY STATE CARROLL MD			
24. FUNERAL DIRECTOR NAME Robert A. Myers 91 Willis St Westminister Md. 21157					25a. DATE REC'D. BY REGISTRAR JAN 29 1987		25b. REGISTRAR'S SIGNATURE Julius Frederick Pendergast		

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

042486 JAN 30 1987

1. DECEASED NAME (TYPE OR PRINT) MILTON V. BARNES			2a. DATE OF DEATH MONTH DAY YEAR 1-25-87			2b. HOUR 3:22 AM	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 6-21-09		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTO. CO., GENERAL HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY DEPT. OF EDUCATION	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JESSE BARNES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALICE		13e. STREET ADDRESS / ZIP CODE 2732 RIGGS AVENUE 21216		BALTO, MO.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 214-01-2746		17. INFORMANT MRS. BALTIMORE, MO, 21216 VIOLA BARNES 2732 RIGGS AVENUE			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIO RESPIRATORY ARREST

DUE TO, OR AS A CONSEQUENCE OF

(b)

Ring abscess

DUE TO, OR AS A CONSEQUENCE OF

(c)

Klebsiella Pneumoniae

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1-12-1987, to 1-25-1987, that (I) (we) last saw the deceased alive on 1-25-1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R. DEPESTRE MD		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-25-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. DEPESTRE		22e. ADDRESS BALTIMORE COUNTY GENERAL HOS					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/31/1987		23c. NAME OF CEMETERY OR CREMATORY MD. NATIONAL MEM. PK		23d. LOCATION CITY OR TOWN COUNTY STATE LAUREL, MARYLAND	
24. FUNERAL HOME NAME NOTER + SONS FUNERAL HOME, INC. ADDRESS 2501 GWYNNS FALLS PKWY, BALTO, MD, 21216				25a. DATE RECEIVED JAN 29 1987		25b. REGISTRAR'S SIGNATURE John J. [Signature]	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the decedent be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) William Clement Battle					2a. DATE OF DEATH MONTH DAY YEAR 1 26 87			2b. HOUR 2:10 P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 31 1925		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 0 0		7. IF UNDER 24 HRS HOURS MIN. 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO County MD.					
10. CITY OR TOWN OF DEATH Towson, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) STELLA MARIS HOSPICE						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Psychiatrist		12b. KIND OF BUSINESS OR INDUSTRY Medical	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Timonium		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 309 Lochview Terrace, 21093	
14. FATHER'S NAME FIRST MIDDLE LAST George Cullen Battle				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Marcelline Jenkins							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. Korean 251-28-0743		17. INFORMANT Carolyn C. Battle, 309 Lochview Terrace				21093	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASTROCYTOMA										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) ASTROCYTOMA											
DUE TO, OR AS A CONSEQUENCE OF (c) ASTROCYTOMA											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1-25 , 19 87 , to 1-26 , 19 87 , that (I) (we) last saw the deceased alive on 1-26 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Eddie Nakhuda, M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1-26-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS Stella Maris Hospice Dulaney Valley Rd.-Towson, MD 21204							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/31/87		23c. NAME OF CEMETERY OR CREMATORY Friends Gunpowder Cem. Sparks Balto. Md.		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME J. E. Lowell Lemmon ADDRESS 10 W. Padonia Rd.						25a. DATE REC'D. BY REGISTRAR JAN 29 1987		25b. REGISTRAR'S SIGNATURE Julia Anderson			

BP

WHITE EXAM BOARD

POST BOTTOM PLATE

JAN 8 1981

040180 JAN

UNKNOWN #87-1

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

00307

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN ESTIMATED		<input checked="" type="checkbox"/> MONTH	DAY	YEAR	2b. HOUR
CAROLINE SUSAN BAUER					1 4 1987					M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR	2d. HOUR
Female	White	Sept. 1, 1958		28 YRS.			1 4 1987			7:12 P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Washington, D.C.		U.S.A.				Baltimore County MD				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Chase		Eastern Blvd. & Greenbank Rd.				Constituent Liaison		N.Y. Sen. Office		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
New York		-----		New York		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		785 West End Avenue (10025)		
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
Harold Lackman				Anne B. Berry						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
No		214-80-7939		Harold Lackman; Father;		12932 Tourmaline Terrace; S. Spg., Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cranial injuries & smoke inhalation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MONTH DAY YEAR 1:30 M. 1-4- 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Occupant of train/train collision.						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) railroad tracks		21f. LOCATION STREET Eastern Blvd. &, Chase Greenbank Rd.		CITY OR TOWN Baltimore		COUNTY MD		STATE
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion										
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER		DATE SIGNED 1-5-87		
EXAMINER'S NAME (TYPE OR PRINT)		Charles P. Kokes, M.D.				ADDRESS		111 Penn St., Balto., MD 21201		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial		1/7/87		Beth David Cemetery		Elmont; L.I.; New York				
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
DANZANSKY-GOLDBERG MEM. CHPLS. 1170 Rockville Pike; Rockville, Md. 20852				JAN 7 - 1987		Julia Davidson-Rodgers				

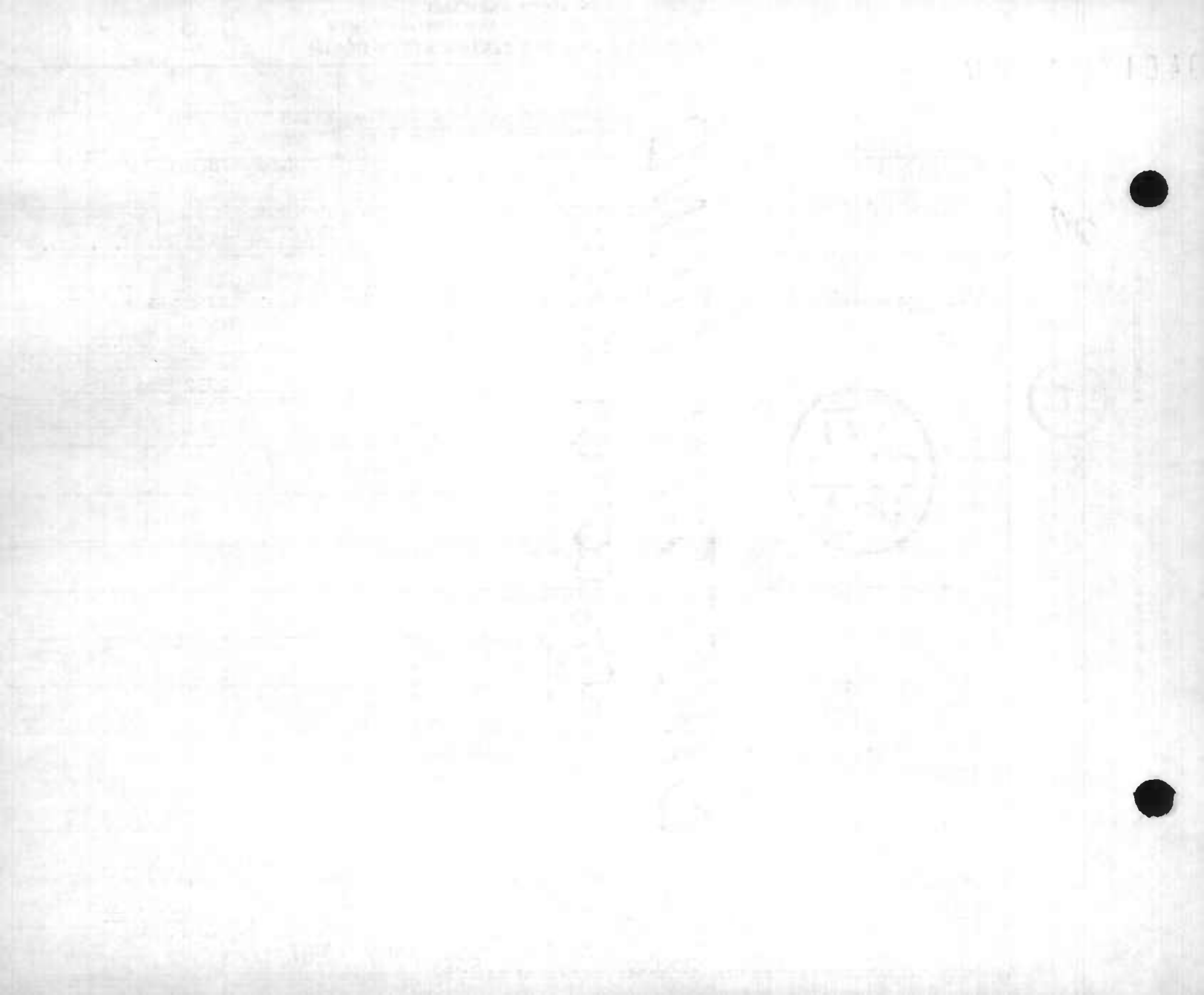
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMITS PAGE 1 AND 2 SHOULD BE USED AS A BURIAL - TRANSIT PERMITS. DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VRS 15 ME (5))



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other immediate event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) Frank J Bauer				2a. DATE OF DEATH MONTH 1 DAY 16 YEAR 87		2b. HOUR 5:15 a M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH 3 DAY 4 YEAR 1894		6. AGE (IN YEARS LAST BIRTHDAY) 92		IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN. 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH County MD.			
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St Joseph.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Insurance Adjustor		12b. KIND OF BUSINESS OR INDUSTRY U.S.F. & G.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland 13c. COUNTY Baltimore 13d. CITY OR TOWN Towson		13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13f. STREET ADDRESS / ZIP CODE 2300 Dulaney Valley Rd. 21204			
14. FATHER'S NAME FIRST Lawrence MIDDLE F. LAST Bauer			15. MOTHER'S MAIDEN NAME FIRST Elizabeth MIDDLE Denges LAST Denges				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-40-5987		17. INFORMANT ADDRESS 1513 Fidelity Building Herbert R. O'Connor, Jr. Balto. Md. 21201			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1-16-87 to 1-16-87 , that (I) (we) lost saw the deceased alive on N/A above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Adel S. EL-Hennawy.		DEGREE MD		22c. DATE SIGNED 1-16-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Adel S. EL-Hennawy.		22e. ADDRESS S J H.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-19-87		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION CITY OR TOWN Baltimore, Maryland COUNTY STATE	
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. ADDRESS 1050 York Rd. Towson, Md. 21204		25a. DATE REC'D. BY REGISTRAR JAN 20		25b. REGISTRAR'S SIGNATURE Julia Dindon-Randall			

BP

212

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040179 JAN 1

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

00309

1. DECEASED NAME (TYPE OR PRINT)			FIRST URIEL			MIDDLE PHILIP			LAST BAUER			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 1 4 19 87			2b. HOUR M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 23, 1959		6. AGE (IN YEARS) (LAST BIRTHDAY) 27 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 5 19 87		2d. HOUR 3:57 A M					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD					
10. CITY OR TOWN OF DEATH Chase				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Eastern Blvd. & Greenbank Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney				12b. KIND OF BUSINESS OR INDUSTRY Law Firm					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE New York		13b. COUNTY -----		13c. CITY OR TOWN New York		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 785 West End Avenue (10025)					
14. FATHER'S NAME FIRST MIDDLE LAST Harry Bauer Lore				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lore Loebel				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 057-42-2415					
17. INFORMANT New York 11516 Harry Bauer; Father; 66 Sealy Dr.; Lawrence,																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compression asphyxia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR <u>1:30</u> P.M. MONTH DAY YEAR 1-4- 19 87				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Occupant of train/train collision.									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) railroad tracks				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Eastern Blvd. &, Chase Baltimore MD Greenbank Rd.									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion																	
ACTUAL SIGNATURE <u>Margarita A. Korell</u>				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 1-5-87									
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn St., Balto., MD 21201													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/7/87		23c. NAME OF CEMETERY OR CREMATORY Beth David Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Elmont, L.I., New York							
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852				25a. DATE REC'D. BY REGISTRAR JAN 7 - 1987				25b. REGISTRAR'S SIGNATURE <u>Julia Friedman-Pollock</u>									

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(4-7-85 NE(5))

999999

040201 JAN

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

 DHMH - 17
 (VR A15 ME (1))
 15M 2/80

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

00310

 1- FOR
 STATE
 REGISTRAR

1. DECEASED NAME

(TYPE OR PRINT)

FIRST

MIDDLE

LAST

HOWARD

BAZE

3. SEX

MALE

4. RACE

COA

5. DATE OF BIRTH

5-14-54

6. AGE (IN YEARS)

32 YRS.

IF UNDER 1 YR.

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

2a. DATE KNOWN OF DEATH

111987

2b. HOUR

238 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

BALTIMORE MD

7b. CITIZEN OF WHAT COUNTRY?

U.S.A

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE CO

10. CITY OR TOWN OF DEATH

PIKESVILLE

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

904 SCOTT'S HILL DRIVE

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

UNEMPLOYED

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MARYLAND

13b. COUNTY

BALTIMORE

13c. CITY OR TOWN

PIKESVILLE

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

904 SCOTT'S HILL DRIVE 21208

14. FATHER'S NAME

EUGENE BAZE SR

15. MOTHER'S MAIDEN NAME

MARGARET PHILLIPS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

NO

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

17. INFORMANT

MR. JAMES BAZE 904 SCOTT'S HILL DRIVE

71208

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Seizure Discharge

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

30 yrs

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opiniondeath resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

STANLEY Z. Felsenberg

TITLE (SPECIFY)

M.D. Deputy

MEDICAL EXAMINER

DATE SIGNED

1/1/87

EXAMINER'S NAME

(TYPE OR PRINT)

STANLEY Z. Felsenberg MD

ADDRESS

11 E. Chas 21202

23a. BURIAL, CREMATION, REMOVAL

(SPECIFY)

BURIAL

23b. DATE

1-6-87

23c. NAME OF CEMETERY OR CREMATORY

MT ZION CEM

23d. LOCATION

CITY OR TOWN

BALTIMORE CO, MD

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

JOSEPH L. RUSS 2222 W. NORTH AVE

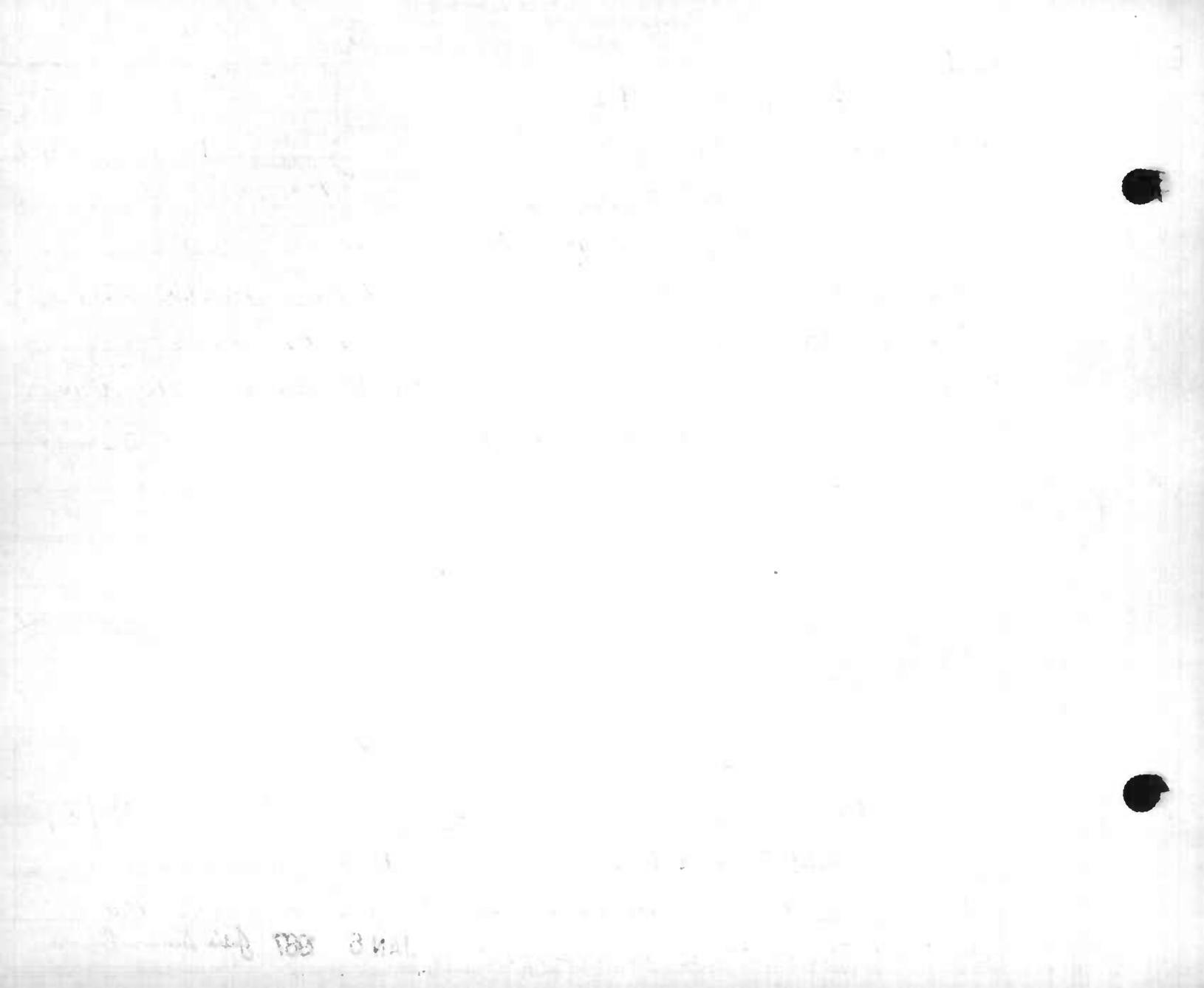
ADDRESS

25a. DATE REC'D. BY REGISTRAR

JAN 6 1987

25b. REGISTRAR'S SIGNATURE

Julia Danden-Randall



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

7 00311

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Lillian M. Becker			2a. DATE OF DEATH MONTH DAY YEAR 1 26 87		2b. HOUR 5¹⁵ AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 4 25 1894		6. AGE (IN YEARS (LAST BIRTHDAY)) 92 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH GARRISON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GARRISON VALLEY CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK	12b. KIND OF BUSINESS OR INDUSTRY DEPT. STORE	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MARYLAND	13b. COUNTY BALTIMORE	13c. CITY OR TOWN PARKVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 8720 AVONDALE ROAD 21234	
14. FATHER'S NAME FIRST MIDDLE LAST LORRAO BECKER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE M. HAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215 032117		17. INFORMANT ADDRESS FAMILY RECORDS	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) MAN 4 years					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Alzheimer's Disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 8-15- 19 86 , to 1-26- 19 87 , that (I) (we) last saw the deceased alive on 1-26-87 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Shaukat Y. Khan		DEGREE M.D.		22c. DATE SIGNED 1-28-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHAUKAT Y. KHAN		22e. ADDRESS 1528 KING WILLIAM DRIVE, BALTO, MD 21228			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 1-29-1987	23c. NAME OF CEMETERY OR CREMATORY HOLY REDEMPTION	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		
24. FUNERAL DIRECTOR NAME EVANS F.H.		ADDRESS 2830 HARFORD ROAD		25a. DATE REG'D. BY REGISTRAR FEB 3 1987	25b. REGISTRAR'S SIGNATURE Julius Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the bottom papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other notable event, the medical examiner must be notified at once.

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10011

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BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please attach the carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Mary Frances Beckman			2a. DATE OF DEATH MONTH DAY YEAR January 4, 1987		2b. HOUR 1:40 PM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 21, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Bayrd, W. Va.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Middle River 21220		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY OR COUNTY, GIVE STREET AND CITY) 10322 Bird River Rd.		12a. USUAL OCCUPATION (TYPE OF WORK OR INDUSTRY OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY home
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland			13b. CITY OR TOWN Baltimore	13c. STREET ADDRESS / ZIP CODE 10322 Bird River Rd. 21220		
14. FATHER'S NAME William Kitzmiller			15. MOTHER'S MAIDEN NAME Emily Bosley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 215 28 9328		17. INFORMANT ADDRESS Donald E. Beckman, Son Same		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thromboses DUE TO, OR AS A CONSEQUENCE OF (b) Gen. arterio-sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) acute fibr. infarction PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 1974 , 19____, to 1/4/87 , 19____, that (I) (we) lost saw the deceased alive on 1/4/87 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.						
22b. SIGNATURE R. S. MAGN		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/6/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. S. MAGN, MD		22e. ADDRESS 2811 Wis. Ave BALD. MD. 21222				
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 1/8/87		23c. NAME OF CEMETERY OR CREMATORY Pleasant Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Oakland, Md.
24. FUNERAL DIRECTOR Brudzinski Funeral Home P.A., 1407 Old Eastern Ave 21221				25a. DATE REC'D. BY REGISTRAR JAN 7 1987		25b. REGISTRAR'S SIGNATURE [Signature]

January 4, 1987

John Thomas Jackson

82

Jan. 21, 1901

White

Female

Baltimore County

x

ADA

Card, W. Va.

Home

Housewife

10352 River Rd.

White River - 2111

10352 River Rd. 21220

x

White River

Admission

Admission

Miss Foster

William Mitchell

Home

Donna L. Jackson, son

212 22 0228

no

Admission, W.

Admission, W.

1/8/87

Admission

Admission, W. A. Jackson, son

21220

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be called upon.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 00313	
1. DECEASED NAME (TYPE OR PRINT) EUGENE GRABER BELZ, SR.					2a. DATE OF DEATH JANUARY 09, 1987			2b. HOUR 7 ⁰⁵ P. M.			
1. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 21, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH'S HOSPITAL				12a. USUAL OCCUPATION (USE WORK FOR MOST OF WORKING LIFE) Self Emp. Balto.		12b. KIND OF BUSINESS OR INDUSTRY Mimeograph			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. CITY Baltimore 13c. CITY OR TOWN Lutherville					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 311 Felton Rd. 21093				
14. FATHER'S NAME FIRST MIDDLE LAST Peter Eugene Belz, Jr.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Regina Mary Graber						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-03-8900		17. INFORMANT ADDRESS Mrs. Helen M. Belz, same as #13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerotic Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ischemic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 YEARS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Diabetes mellitus</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) this hospital attended the deceased from <u>May 9</u> , 19 <u>85</u> , to <u>Jan 9</u> , 19 <u>87</u> , that (II) (we) last saw the deceased alive on <u>Jan 9</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Walter R. Welzant, MD</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>Jan 10, 1987</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER R. WELZANT, MD					22e. ADDRESS 6100 YORK RD. 21212						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-13-87		23c. NAME OF CEMETERY OR CREMATORY New Cathedral			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. 21204					25a. DATE REC'D. BY REGISTRAR JAN 14 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Tondra-Rudolph</u>				

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

67 00314

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Anthony Bennett			2a. DATE OF DEATH MONTH DAY YEAR January 30 1987			2b. HOUR M 	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 23 1911		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Middle River		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 846 Seneca Park Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Middle River		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> **	
13e. STREET ADDRESS 846 Seneca Park Road		13f. ZIP CODE 21220		14. FATHER'S NAME FIRST MIDDLE LAST John Bennett		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Perkner	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-05-4354		17. INFORMANT Irene Bennett		17. ADDRESS 846 Seneca Park Road 21220	
18. CAUSE OF DEATH (Enter only one cause per line on (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pleural effusion DUE TO OR AS A CONSEQUENCE OF (b) Metastatic small cell carcinoma DUE TO OR AS A CONSEQUENCE OF (c) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immed
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Jan 23, 1985 , to Jan 30, 1987 , that (I) (not lost) saw the deceased alive on Jan 16, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dr. Louis Semenoff		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/31/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Louis Semenoff		22e. ADDRESS 2108 Orem Road, Balt Md 21220					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/2/87		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Rossville Balto. Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Connelly Funeral Home 300 Mace Ave. 21221				25a. DATE REC'D. BY REGISTRAR FEB - 4 1987		25b. REGISTRAR'S SIGNATURE John P. ...	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic agent, the medical examiner shall be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please receive the body of the deceased. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

042999 FEB-58

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

OFFICE OF THE
DIRECTOR OF THE
BUREAU OF THE
LAND OFFICE

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

00315

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ARTLY O. BENNY			2a. DATE OF DEATH MONTH DAY YEAR 1/29/87		2b. HOUR 5:05 AM		
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 9-16-1896		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS	
7a. BIRTHPLACE (COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto Co. MD.	
10. CITY OR TOWN OF DEATH Balto		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MORRIS F. ROSENTHAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HUCKSTER		12b. KIND OF BUSINESS OR INDUSTRY PRODUCE	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.				13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.	
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT BENNY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LAURA MOORE			

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-10-3202		17. INFORMANT ADDRESS Mr. Robert Benny - 1914 Mansdale Rd. 21222	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) S/P Removal of ear for cancer DUE TO, OR AS A CONSEQUENCE OF (c) ear for cancer		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days weeks	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/24 , 19 84 , to 1/29 , 19 87 , that (I) (we) last saw the deceased alive on 1/29 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Joseph G. Ouslander M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH OUSLANDER				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2-2-87		23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.	
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24. FUNERAL DIRECTOR NAME ADDRESS Walter J. Heller - 7527 Harford Rd.		25a. DATE REC'D. BY REGISTRAR FEB 2 - 1987		25b. REGISTRAR'S SIGNATURE Lisa J. J. J. J.	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner will be notified and a post-mortem examination will be required.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR STATE REGISTRAR					REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) ANNA BERG					2a. DATE OF DEATH MONTH DAY YEAR JAN. 4, 1987			2b. HOUR 9 A. M.	
3. SEX FEMALE		4 RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR APRIL 10, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2822 MARNAT RD. 21209				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2822 MARNAT RD. 21209	
14. FATHER'S NAME FIRST MIDDLE LAST REUVEN TUCKER					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRED A UNKNOWN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-18-0278		17. INFORMANT ADDRESS DR. LOUIS P. GREENBERG, APT. 808 111 HAMLET HILL RD. BALTO, MD 21210					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute MI</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Intermittent Cardiac Arrest</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. <u>acute fibrillation, ASCVD</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>acute fibrillation, ASCVD</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>acute</u> <u>acute</u> <u>6 yrs</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <u>10-25</u> , 19 <u>76</u> , to <u>1-4</u> , 19 <u>87</u> , that (we) last saw the deceased alive on <u>8-15</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE H. Gerald Oster M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-5-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Gerald Oster					22e. ADDRESS 3635 Old Court Rd.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/6/87		23c. NAME OF CEMETERY OR CREMATORY MOSES MONTEFIORE CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD		23e. DATE REC'D. BY REGISTRAR	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO, MD 21215					25. REGISTRAR'S SIGNATURE JAN 13 1987				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then it should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, accident, or violent event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then the certificate and carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the event.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) Elise K. Bergmann					2a. DATE OF DEATH MONTH DAY YEAR January 28, 1987					2b. HOUR 6:40 p.m.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 19, 1902			6. AGE (IN YEARS LAST BIRTHDAY) 84		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Valley Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6401 Loch Raven Blvd. 21239			
14. FATHER'S NAME FIRST MIDDLE LAST Knapp				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST -							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 220-22-9020		17. INFORMANT ADDRESS Mrs. Margaret G. Taylor 922 Litchfield Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Marion C. Kowalewski						DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1/29/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marion C. Kowalewski MD						22e. ADDRESS 8604 Harford Rd. Baltimore, Maryland					
23a. BURIAL, CREMATION, REMOVAL (TYPE) Cremation			23b. DATE 1-30-87		23c. NAME OF CEMETERY OR CREMATORY Westview Memorial			23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto. Md.			
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Baltimore, Maryland						25a. DATE REC'D BY REGISTRAR JAN 30 1987			25b. REGISTRAR'S SIGNATURE		

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January 18, 1907

Dear Sir

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Chicago, Illinois

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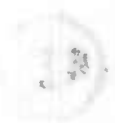
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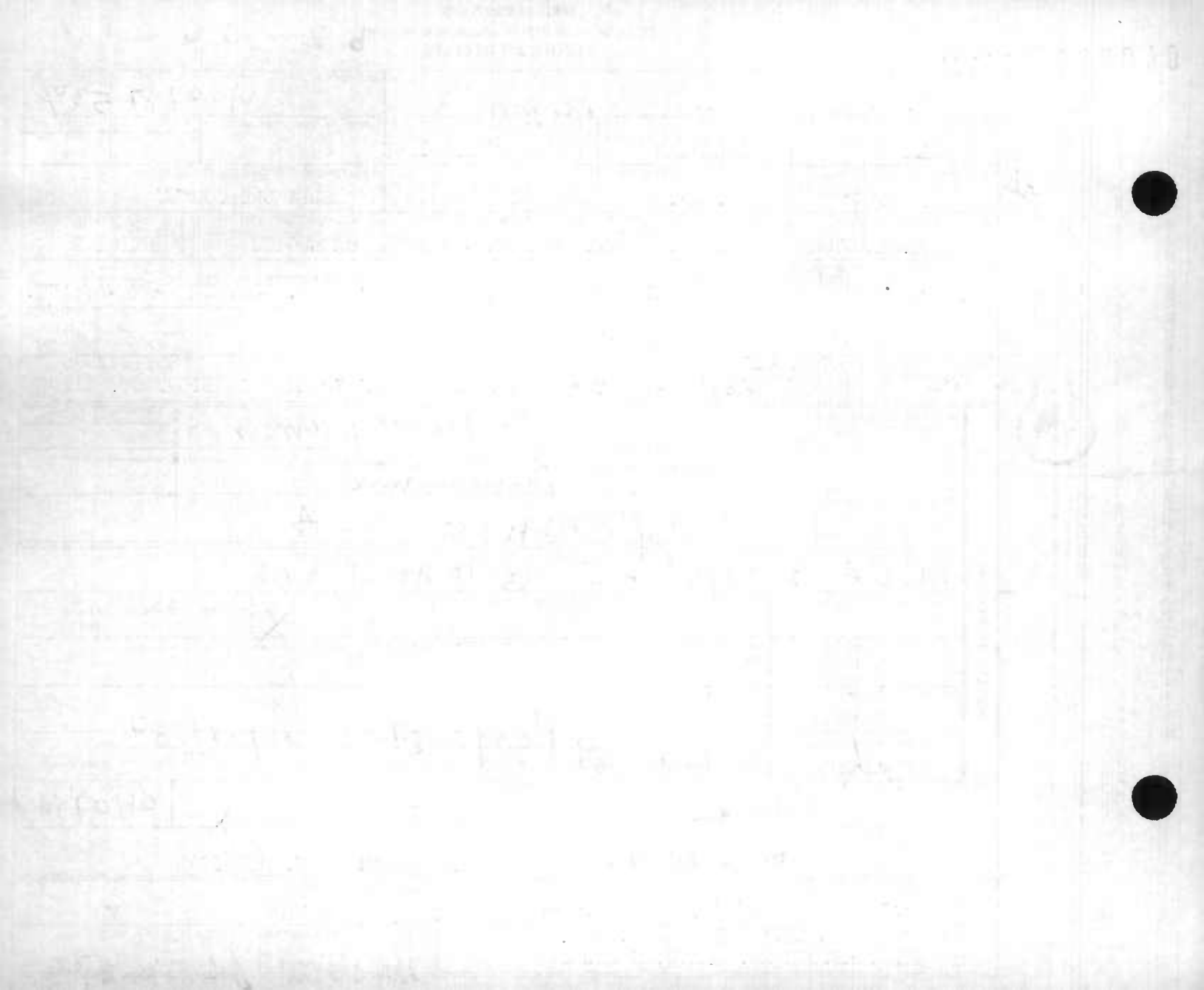
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. FOR STATE REGISTRAR					7 00319							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DR. Henry I. Berman					2a. DATE OF DEATH MONTH DAY YEAR 01 07 87		2b. HOUR 53 ^{PM}					
3 SEX MALE		4 RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR FEBRUARY 19, 1906		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS		7. IF UNDER 1 YEAR (MONTHS) DAYS		7b. IF UNDER 72 HRS (HOURS) MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD						
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTO. COUNTY GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UROLOGIST		12b. KIND OF BUSINESS OR INDUSTRY MEDICINE				
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 1190 W. NORTHERN PARKWAY, APT. 21210 304						
14. FATHER'S NAME FIRST MIDDLE LAST SOLOMON BERNMAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADA KATE NOCHUMOWITZ								
16a. WAS DECEASED EVER IN ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 236-28-5894		17. INFORMANT ADDRESS SUITE 2300 MR. S. LEONARD SOLLINS 10 LIGHT ST. 21202								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 7 912 } <i>Respiratory distress</i> <i>pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ ① ASPIRATION ② CVA										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) ① CVA ② Hypertension ③ INANITION												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 01/02/87 to 01/07/87, that (I) (we) last saw the deceased alive on 01/07/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) not view the body after death.												
22b. SIGNATURE <i>[Signature]</i>				DEGREE				22c. DATE SIGNED 01/07/87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. ENOUR				22e. ADDRESS BALTO COUNTY GEN. HOSPITAL								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/8/87		23c. NAME OF CEMETERY OR CREMATORY BETH TFILOH CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD						
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD. BALTO, MD 21215						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE JAN 13 1987 <i>[Signature]</i>				

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the folder and return it to the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic cause, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN W. BICKING					2a. DATE OF DEATH MONTH DAY YEAR 1 23 87					2b. HOUR 2:30A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 23 07		6. AGE (IN YEARS (LAST BIRTHDAY)) 79 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1207 Brandford Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sunpaper carrier			12b. KIND OF BUSINESS OR INDUSTRY Sunpaper		
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1207 Brandford road 21228			
14. FATHER'S NAME FIRST MIDDLE LAST John Richard Bicking				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Beck							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 1943-1967		17. INFORMANT ADDRESS Helene W. Bicking 1207 Brandford rd. 21228					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic obstructive pulmonary disease (b) Arteriosclerotic Cardiovascular Disease with (c) old MI & multiple Arrhythmias DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20/Yrs 2 Yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED: WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1956 to 1/23/87, that (I) <input checked="" type="checkbox"/> saw the deceased alive on Dec 19 1986 and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.											
22b. SIGNATURE J E McGrath				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/23/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) McGrath William E.				22e. ADDRESS 1303 Frederick Avenue				21d 28 md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/28/87		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park			23d. LOCATION CITY OR TOWN Elkridge		23e. HOWARD COUNTY MD.		
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.				24b. ADDRESS 21229		25a. DATE REC'D. BY REGISTRAR JAN 28 1987		25b. REGISTRAR'S SIGNATURE John B. ...			

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12/24/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ruth Kathleen Bicknell			2a. DATE OF DEATH MONTH DAY YEAR January 3, 1987		2b. HOUR M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR January 17, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Woodlawn	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6720 Ransome Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Agent--O'Connor,		12b. KIND OF BUSINESS OR INDUSTRY Piper & Flynn
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Woodlawn	13d. STREET ADDRESS / ZIP CODE 6720 Ransome Drive 21207	
14. FATHER'S NAME FIRST MIDDLE LAST Patrick Joseph Kelly			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Conway		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --- 098-14-4421		17. INFORMANT Baltimore, MD 21207 Mr. Forest B. Bicknell 6720 Ransome Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prostatic Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION _____		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR--A.M. MONTH-- DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/22</u> , 19 <u>84</u> , to <u>1/3</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>11/21</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Richard Gross</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>1/4/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Gross		22e. ADDRESS ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-8-87		23c. NAME OF CEMETERY OR CREMATORY St. Lawrence Church	
23d. LOCATION CITY OR TOWN COUNTY STATE Sayville Suffolk NY		23e. DATE REC'D. BY REGISTRAR JAN 5 1987			
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc. ADDRESS 8728 Liberty Rd. Randallstown, MD 21133		25b. REGISTRAR'S SIGNATURE <u>Julia Sinden-Rudner</u>			

BP _____

100-100000

041829 JAN 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 00322

REG. NO.

5:51 P.M.

1. DECEASED NAME (TYPE OR PRINT) ROSE H. BERNSTEIN		2a. DATE OF DEATH MONTH DAY YEAR 1-15-87		2b. HOUR 1:51 PM	
3. SEX FEMALE	4. RACE W HITE	5. DATE OF BIRTH MONTH DAY YEAR 2-15-00		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN) RUSSIA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH RANDALLSTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION BALTIMORE COUNTY GEN. HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK OR ACTIVITY DURING WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY BALTO	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS VARSUBSKY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HILDA POTLUCK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-20-8804		17. INFORMANT MR. MARVIN BERNSTEIN ADDRESS 5 COOL SPRING CT. LUTHERVILLE, MD 21093	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (c) POSSIBLE MI; VENTRICULAR TACH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: AORTIC STENOSIS, PULMONARY FIBROSIS, ASCD, ANEMIA					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/4/84 to 1/15/87, that (I) (we) last saw the deceased alive on 1/15/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE A. ENRIQUE		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/16/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A ENRIQUE		22e. ADDRESS 2435 W BELVEDERE BALTO MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JAN. 19, 1987		23c. NAME OF CEMETERY OR CREMATORY ANSHE EMUNAH	
23d. LOCATION CITY OR TOWN BALTIMORE		COUNTY BALTO		STATE MARYLAND	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO, MD 21215				25a. DATE REC'D. BY REGISTRAR JAN 28 1987	
25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 00323

FOR
STATE*
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Adolph R. Beyer			2a. DATE OF DEATH MONTH DAY YEAR Jan. 21, 1987			2b. HOUR M	
3 SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 11 1909		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) Balto. Co. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. MD.	
10. CITY OR TOWN OF DEATH Kingsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11607 Mohr Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Grocer		12b. KIND OF BUSINESS OR INDUSTRY Self-Employee	
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Kingsville	
14. FATHER'S NAME FIRST MIDDLE LAST August Beyer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Stetler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-42-4034		17. INFORMANT ADDRESS 21087 Emma G. Beyer 11607 Mohr Rd. Kingsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastasis Cancer DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from June 19 86, to Jan 19 87, that (I) (we) lost saw the deceased alive on Aug 1 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dr. Hitzig				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/29/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Hitzig				22e. ADDRESS 300 E. Joppa Rd. Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-24-1987		23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville Balto. Md.	
24. FUNERAL DIRECTOR NAME ADDRESS E.F. Lassahn F.H. 11750 Belair Rd. Kingsville, Md. 21087				25a. DATE REC'D. BY REGISTRAR FEB 3 1987		25b. REGISTRAR'S SIGNATURE Julia...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card in papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked on item 18 show any injury or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 00324

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) MARIE D. BLACKBURN			2a DATE OF DEATH MONTH DAY YEAR 1-1-87		2b HOUR 8 A M	
3 SEX FEMALE		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 10-03-1901		
6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9 BALTIMORE CITY OR COUNTY OF DEATH BALTO. CO. MD.						
10 CITY OR TOWN OF DEATH Dundalk		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Nrs Ctr-Heritage		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook-Reads Drugs & Chemicals		
12b KIND OF BUSINESS OR INDUSTRY						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a STATE MD		13b COUNTY BALTO		13c CITY OR TOWN Dundalk		
14 FATHER'S NAME FIRST MIDDLE LAST William Deferer		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Not Known				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 216-09-1471		17 INFORMANT ADDRESS Maurice S. Blackburn, Jr. 3405 Yardley Dr.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.A.D. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Carcinoma of the Colon, Aging Brain Syndrome						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from 03/25/1983 to 1/1/1987 , that (I) (we) lost saw the deceased alive on 12/30/1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE K. Dharma Sena		DEGREE M.D.		22c DATE SIGNED 01/01/87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) K. DHARMA SENA		22e ADDRESS #8, 16th AVE. Balt. Md 21225				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 1-5-87		23c NAME OF CEMETERY OR CREMATORY Woodlawn		
23d LOCATION Woodlawn Maryland		STATE				
24 FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk		25a DATE REC'D. BY REGISTRAR JAN 6 1987		25b REGISTRAR'S SIGNATURE Julia Davis-Landace		
25c ADDRESS 7922 Wise Ave. Dundalk, MD 21222						

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please enclose certificate papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified if one.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William P Blackburn Jr.			2a. DATE OF DEATH MONTH DAY YEAR Jan. 29 87			2b. HOUR 2:55 P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 12 1923		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Owings Mills		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3723 Crondall La. Owings Mills				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired - State of Maryland		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Owings Mills		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3723 Crondall Lane 21117	
14. FATHER'S NAME FIRST MIDDLE LAST William P. Blackburn Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Stephens					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 219-22-5220		17. INFORMANT ADDRESS Stephen D. Blackburn 3511 Mazzone Dr. Reno, Nevada 89502			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Myocardial Infarction

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

minutes

DUE TO, OR AS A CONSEQUENCE OF

(b)

Atherosclerosis

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

Chronic Lung Disease

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 27</u> 19 <u>87</u> , to <u>Jan 29</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Jan 27</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dr. David Miller				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-30-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. David Miller				22e. ADDRESS 10219 S. Dolfield Rd. Owings Mills 21117			

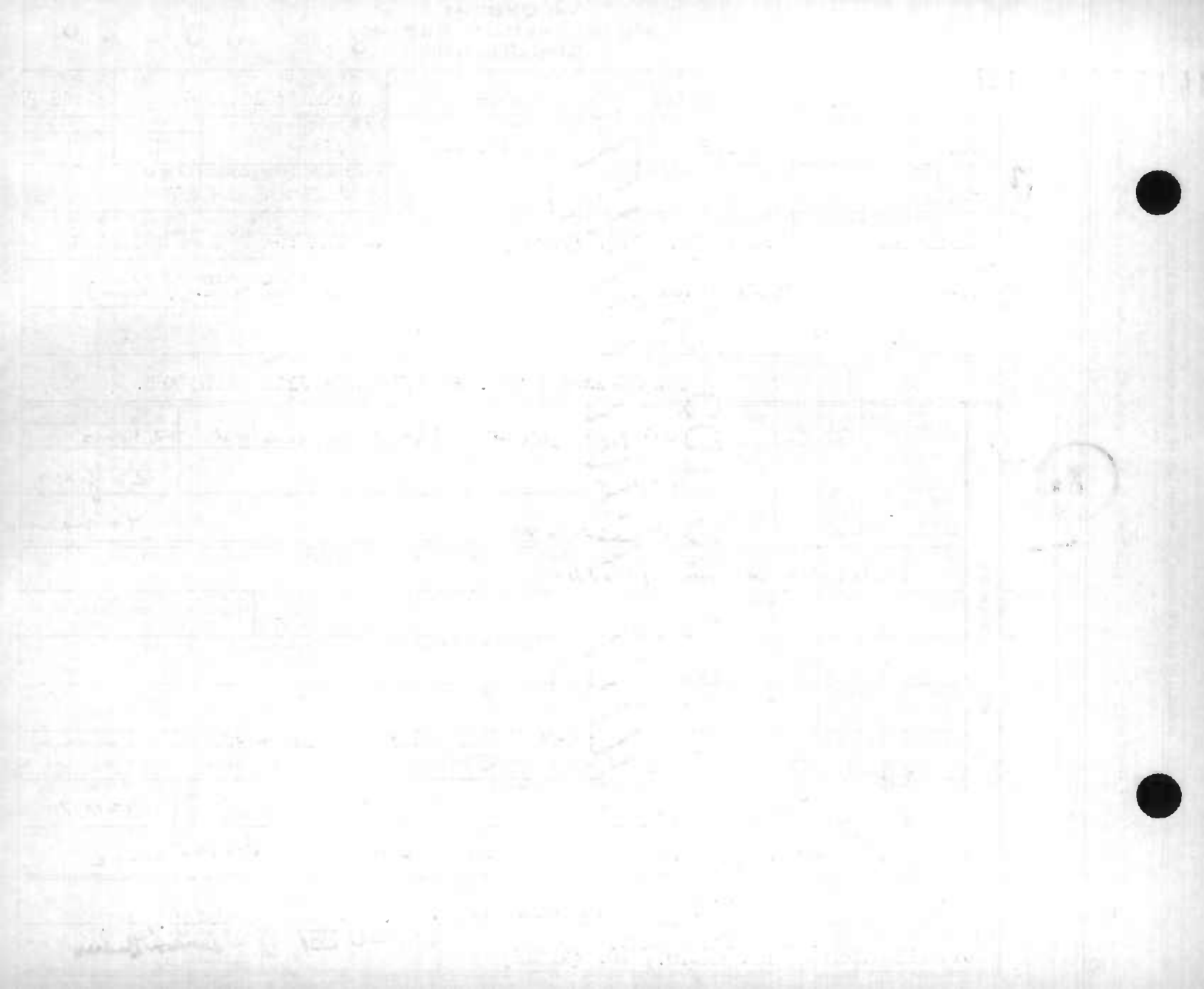
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-2-87		23c. NAME OF CEMETERY OR CREMATORY Evergreen Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Finksburg Carroll Md.	
24. FUNERAL DIRECTOR NAME Eline Funeral Home Reisterstown, Md.				25a. DATE REC'D. BY REGISTRAR FEB 4 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Pendley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examination must be notified.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the physician who certifies death must be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to the proper pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 37 00327	
1. DECEASED NAME (TYPE OR PRINT) Charles R BOHRER			2a. DATE OF DEATH MONTH DAY YEAR January 22, 1987		2b. HOUR 6:55AM	
3 SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 03 25 15		6. AGE (IN YEARS (LAST BIRTHDAY)) 71 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.
10. CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY SMELTING
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN ROSEDALE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST HENRY NELSON BOHRER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DORA B. ---		13e. STREET ADDRESS / ZIP CODE 1224 LANDOVER RD. 21237		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 232-07-7614		17. INFORMANT ADDRESS MAE BOHRER 1224 LANDOVER RD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF <u>Metastatic Prostate Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>and end stage Chronic Obstructive Pulmonary Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>January 14, 1987</u> to <u>January 22, 1987</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>January 22, 1987</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.						
22b. SIGNATURE <i>Lisa Beasley</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/22/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lisa Beasley M.D.		22e. ADDRESS 9000 Franklin Square Drive		22f. ZIP CODE 21237		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 01/26/87		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. BALTO. MD.
24. FUNERAL DIRECTOR NAME <i>John Frank</i>		ADDRESS 1211 Chesapeake		25a. DATE REC'D. BY REGISTRAR JAN 28 1987		25b. REGISTRAR'S SIGNATURE <i>Lisa Beasley</i>

210
WILKINSON ROAD

043015 FEB-51

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 00328
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILLIAM D BOLLINGER			2a. DATE OF DEATH MONTH DAY YEAR 1 28 87			2b. HOUR 7:05 A.M.			
3. SEX MALE		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 02 04 08		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		9b. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH TOWSON, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney		12b. KIND OF BUSINESS OR INDUSTRY Banking	
13a. STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN TOWSON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST J. Edward Bollinger				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hannah E. Foster				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
16b. SOCIAL SECURITY NO. 318 07 8700				17. INFORMANT Mrs. Alice B. Miller				ADDRESS 21228 1507 Park Grove Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral infarction, ischemic DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis, generalized DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 days 2 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Resect to carcinoma, colon -									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1-10-87, 1987, to 1-28-87, 1987, that (I) (we) last saw the deceased alive on 1-28-87, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Wm Carl Ebeling MD						DEGREE MD		22c. DATE SIGNED 1-28-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm CARL EBELING MD						22e. ADDRESS 7401 Osceola Dr Baltimore 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/31/87		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.		
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.						25a. DATE REC'D. BY REGISTRAR FEB 4 1987		25b. REGISTRAR'S SIGNATURE John E. ...	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page is removed from the papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

BP

040125 JAN 6 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

REG. NO.

00329

FOR
STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST MIDDLE LAST
WILLIE (CLIFTON) BOONE

2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR P
1 3 87 5:00 P

3. SEX

MALE

4. RACE

BLACK

5. DATE OF BIRTH

MONTH DAY YEAR 12 07 42

6. AGE (IN YEARS LAST BIRTHDAY)

44

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C.

7b. CITIZEN OF WHAT COUNTRY?

USA

8

MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE COUNTY

MD.

10. CITY OR TOWN OF DEATH
TOWSON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
GBMC-6701 N.CHARLES ST.

12a. USUAL OCCUPATION (TYPE OF WORK OR WORKING LIFE)
LABORER

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13b. STATE
MD

13c. COUNTY
BALTO.

13d. CITY OR TOWN
BALTO.

13e. INSIDE CITY LIMITS?
YES ☐ NO ☐

13f. STREET ADDRESS / ZIP CODE
1300 ANGLE SEA ST. APT. B-2

21229

14. FATHER'S NAME

FIRST MIDDLE LAST
CLIFTON

BOONE, SR.

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST
ADDIE

PERSON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)

243644766

17. INFORMANT

ADDRESS

JULIA BOONE 1300 ANGLE SEA ST. APT. B-2

18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c)
PART I. DEATH WAS CAUSED BY: RESPIRATORY FAILURE

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF
CANCER OF THE LUNG

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

22a. I certify that (I) (this hospital) attended the deceased from 1-1-87, to 1-3-87, that (I) (we) last saw the deceased alive on 1-3-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

DR. VON FRANKE

22e. ADDRESS

GBMC-6701 N.CHARLES ST.

23a. BURIAL, CREMATION, REMOVAL

BURIAL

23b. DATE

1-6-87

23c. NAME OF CEMETERY OR CREMATORY

GARNAS FUNERAL HOME

23d. LOCATION

HENDERSON

COUNTY

STATE

N.C.

24. FUNERAL DIRECTOR

NAME

ADDRESS

MARCH FUNERAL HOME 1101 E. NORTH AVE.

25a. DATE REC'D. BY REGISTRAR

JAN 5 1987

25b. REGISTRAR'S SIGNATURE

John F. von Franke MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all other papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

2

9

BP

1111-2

77000 - 98000

42026 JAN 29 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 00330

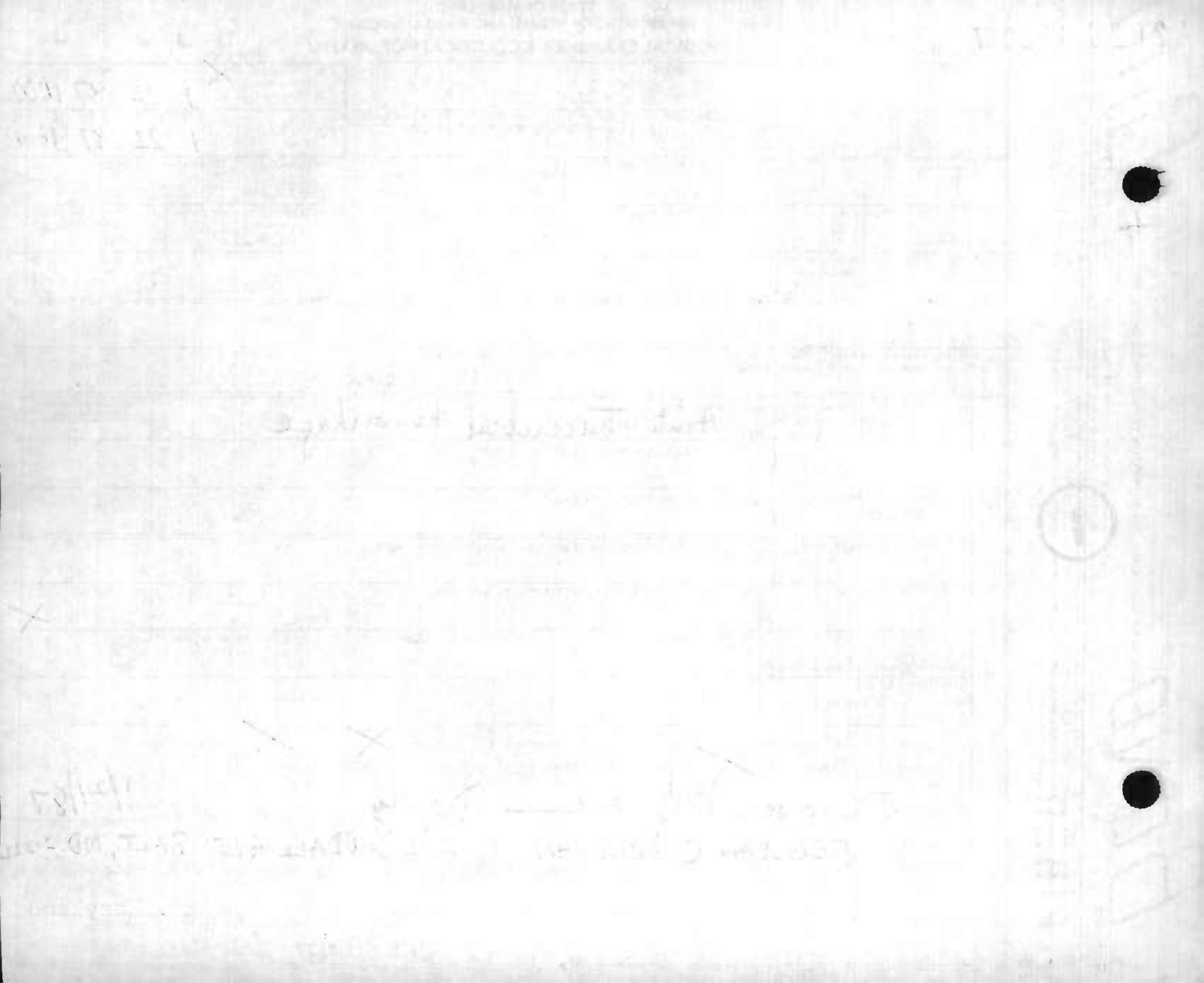
1. DECEASED NAME (TYPE OR PRINT) Anna Boretzky			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 22 1987			2b. HOUR 1000					
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug 20 1896	6. AGE IN YEARS (LAST BIRTHDAY) 90 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD 1 22 1987			2d. HOUR 1610		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Austria		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Essex		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 352 Townsend Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD.			13b. COUNTY Balto.		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 352 Townsend Road 21221	
14. FATHER'S NAME FIRST MIDDLE LAST unknown Bunio			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-74-1779		17. INFORMANT ADDRESS Mike Boretzky 352 Townsend Rd.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute intracerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE J. Crossan O'Donovan M.D.			TITLE (SPECIFY) Deputy			MEDICAL EXAMINER			DATE SIGNED 1/24/87		
EXAMINER'S NAME (TYPE OR PRINT) J. CROSSAN O'DONOVAN			ADDRESS 2112 DUNDALK AVE. BALT, MD. 21221								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/26/87			23c. NAME OF CEMETERY OR CREMATORY SacredHeart of Jesus Dundalk			23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Maryland		
24. FUNERAL DIRECTOR NAME ConnellyFuneralHome			ADDRESS 300MaceAve.21221			25a. DATE REC'D. BY REGISTRAR JAN 28 1987			25b. REGISTRAR'S SIGNATURE Julia Davidson-P.		

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A 15 ME (5))
15M 7/76



043002 FEB

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3M. 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M/7/77

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

00331

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) EZRA HOBEWELL BOSTON			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 1 19 87		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 4 1911	6. AGE (IN YEARS) LAST BIRTHDAY 75 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nebraska		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Essex		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1129 Old Eastern Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Essex	
14. FATHER'S NAME FIRST MIDDLE LAST unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 406-05-2884		17. INFORMANT ADDRESS Arthur Smith 966 Seneca Pk. Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>J. M. Nienhoff</i>		TITLE (SPECIFY) M.D. DEPUTY		DATE SIGNED 1/29/87	
EXAMINER'S NAME (TYPE OR PRINT) J. M. NIENHOFF, M.D.		ADDRESS 6800 MORNINGTON RD. BALTO, MD 21222			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1/30/87		23c. NAME OF CEMETERY OR CREMATORY SecurityProcess	
24. FUNERAL DIRECTOR NAME ConnellyFuneralHome		ADDRESS 300 Mace Ave. 21221		25a. DATE REC'D. BY REGISTRAR FEB 4 1987	
		25b. REGISTRAR'S SIGNATURE <i>Julia Devlin-Rudace</i>			
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					

3

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1-87
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Harold Lee BOULDEN			2a. DATE OF DEATH MONTH DAY YEAR January 19, 1987		2b. HOUR 10:00PM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 02 04 1919		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DELAWARE		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD	
10. CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PAINTER	
13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN WHITE MARSH		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST FRANK --- BOULDEN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLA MAE VOROUS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WWII			
16b. SOCIAL SECURITY NO. 312070704		17. INFORMANT ADDRESS MARY RUTH BOULDEN 11333 PULASKI HWY.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest-Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Severe Malnutrition DUE TO, OR AS A CONSEQUENCE OF (c) Heart Failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 21, 1986 to January 19, 1987 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on January 19, 1987 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.							
22b. SIGNATURE 		DEGREE		22c. DATE SIGNED 1/19/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roy Fontendt M.D.		22e. ADDRESS 9000 Franklin Square Drive 21237					
23a. METHOD OF CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 01/21/87		23c. NAME OF CEMETERY OR CREMATORY WESTVIEW		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO BALTO MD	
24. FUNERAL DIRECTOR NAME 		ADDRESS 1000 Chesapeake Ave		25a. DATE REC'D. BY REGISTRAR JAN 21 1987		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deceased be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as having shown injury, or other traumatic event, the medical examiner must be notified at once.

BP

50% COTTON FIBER

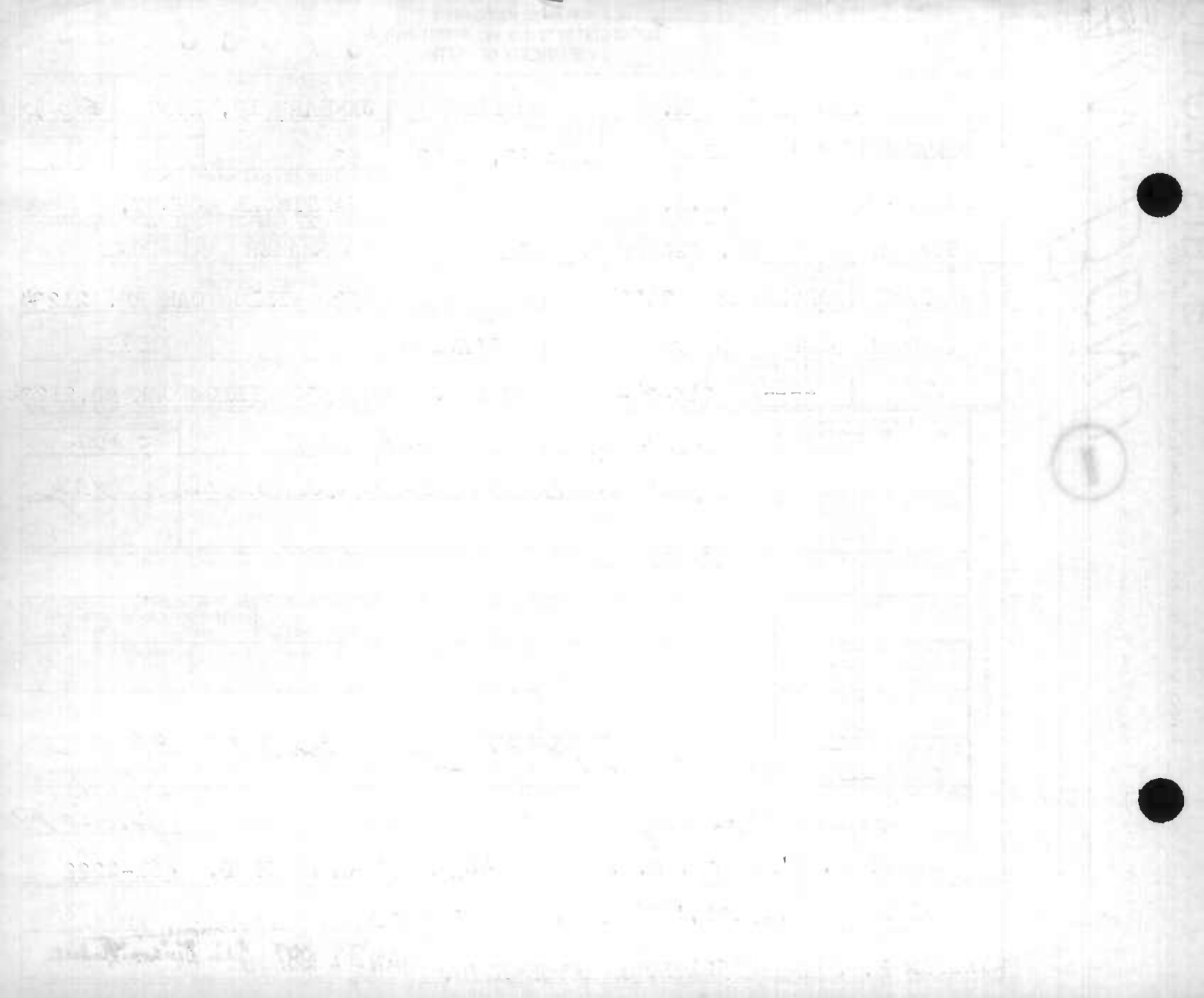
TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the decedent be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the medical examiner and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

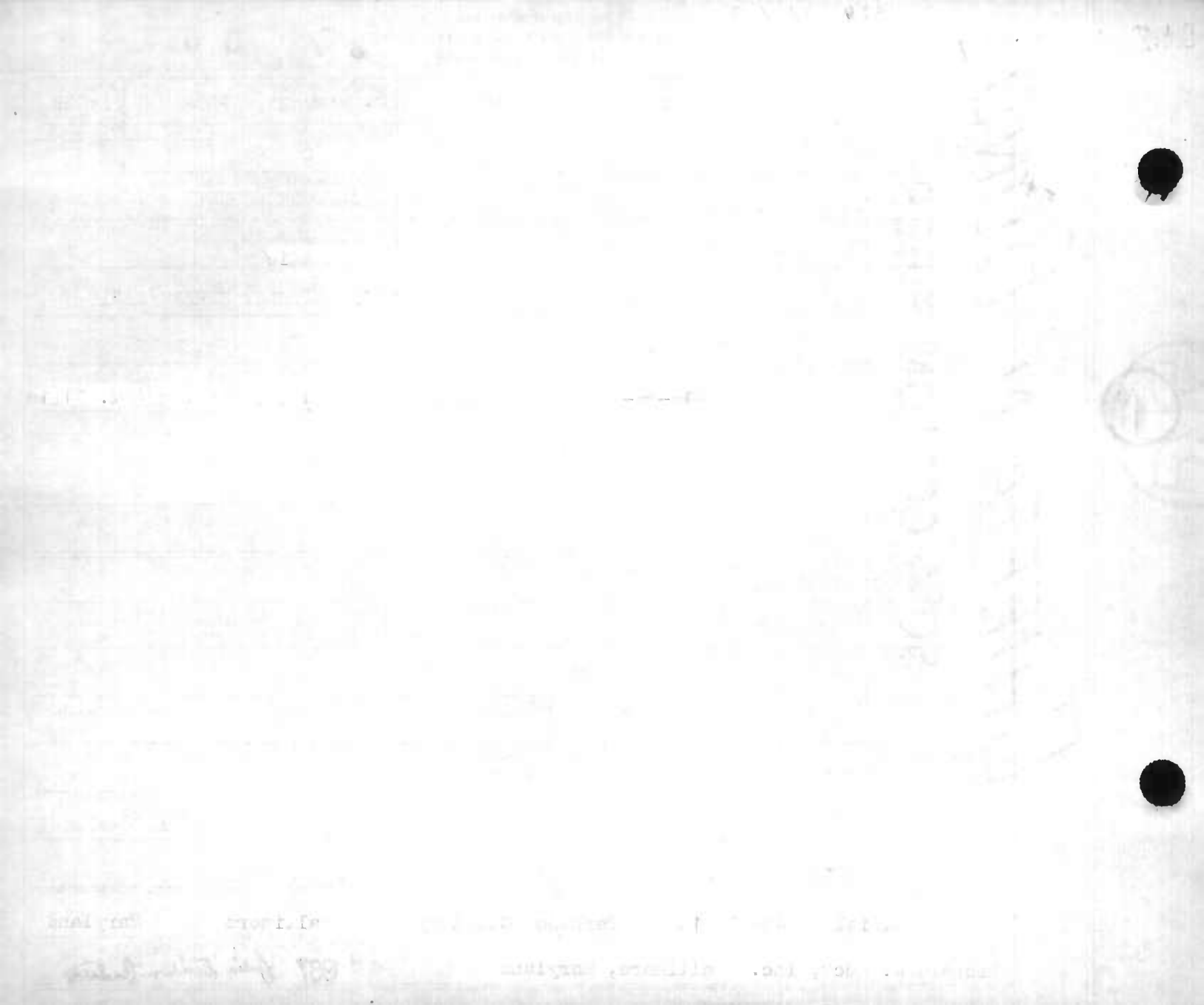
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 87 00333					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET M. BOWERS				2a. DATE OF DEATH MONTH DAY YEAR JANUARY 19, 1987				2b. HOUR 6:30 PM	
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 13, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY, MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. STATE MARYLAND				13b. CITY OR TOWN BALTIMORE		13c. CITY OR TOWN 21234		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH ADAM GRIESER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CAROLINE ELLIS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 215-34-6966		17. INFORMANT ADDRESS NAOMI B. BOGGS 8530 WILLOW OAK RD. 21234			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>10 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>Jan. 24</u> , 19 <u>65</u> , to <u>Jan. 19</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Jan. 14</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>Samuel I. O'Mansky</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>Jan 20 87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAMUEL I. O'MANSKY, M.D.				22e. ADDRESS 8405 LOCH RAVEN BLVD. 661-2222					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE JAN. 22, '87		23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD	
24. FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON				ADDRESS 8521 LOCH RAVEN BLVD.		25a. DATE RECEIVED BY REGISTRAR JAN 21 1987			



1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR M	
ALSTON		EDWARD	BRAKEALL		JANUARY 25, 1987		11:22P	
3 SEX	4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS	
MALE	WHITE		FEBRUARY 5 1926		60 YRS		IF UNDER 24 HRS HOURS MIN.	
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	8b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
PENNSYLVANIA	U.S.A.							
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
FORT HOWARD	VA MEDICAL CENTER		Mechanic					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. INSIDE CITY LIMITS?			
13a. STATE MARYLAND 13b. COUNTY BALTIMORE					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
LLOYD BRAKEALL					GRACE CLARK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS	
YES W.W. 11					220-18 248-26-2424		Marquerite Brakeall 3035 Barclay St. 21218	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONAR CANCER WITH WIDESPREAD METASTASIS DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					DUODENAL ULCER			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (this hospital) attended the deceased from JANUARY 9, 19 87, to JANUARY 25, 19 87, that (we) last saw the deceased alive on JANUARY 25, 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death.		22b. SIGNATURE Bala Duggirala		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-26-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS						
BALA DUGGIRALA, M.D.		VAMC, FORT HOWARD, MD. 21052						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial		Jan 29 1987		Parkwood Cemetery		Baltimore Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Leonard J. Ruck, Inc. Baltimore, Maryland				JAN 28 1987		Julia Davidson-Ruck		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove completion. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



41894 JAN 28 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

7 00335

1 DECEASED NAME (TYPE OR PRINT) Joseph A. Breighner			2a DATE OF DEATH MONTH DAY YEAR 1 23 87			2b HOUR 10:05 A	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 2 10 24		6 AGE (IN YEARS LAST BIRTHDAY) 62	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10 CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Purchasing Agent		12b KIND OF BUSINESS OR INDUSTRY Sippel Elec.	
13a STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e STREET ADDRESS / ZIP CODE 5113 Meridy Ave. Balto.Md.		13f STREET ADDRESS / ZIP CODE 5113 Meridy Ave. Balto.Md.		13g STREET ADDRESS / ZIP CODE 5113 Meridy Ave. Balto.Md.		13h STREET ADDRESS / ZIP CODE 5113 Meridy Ave. Balto.Md.	
14 FATHER'S NAME FIRST MIDDLE LAST Samuel Breighner		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 217-16-3276	
17 INFORMANT Doris A. Breighner		18 ADDRESS 5113 Meridy Ave. 21236		19a DATE OF OPERATION None		19b CONDITION FOR WHICH OPERATION WAS PERFORMED None	
20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) this hospital attended the deceased from April 2, 1986, to Jan 2, 1987, that (we) last saw the deceased alive on Jan 2, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I/we) (did) (did not) view the body after death.		22b SIGNATURE Richard W. Bittrick MD		22c DATE SIGNED 1/23/87		22d PHYSICIAN'S NAME (TYPE OR PRINT) Richard Bittrick (665-4400)	
22e ADDRESS 8100 Harford Rd. Baltimore, Maryland		23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 1-27-87		23c NAME OF CEMETERY OR CREMATORY Moreland Memorial	
23d LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		24 FUNERAL DIRECTOR NAME Lessaun Funeral Home		24b ADDRESS 7401 Belair Rd. BALTO. MD. 21236		25a DATE REC'D. BY REGISTRAR JAN 28 1987	
25b REGISTRAR'S SIGNATURE Julia Denson		25c REGISTRAR'S SIGNATURE Julia Denson		25d REGISTRAR'S SIGNATURE Julia Denson		25e REGISTRAR'S SIGNATURE Julia Denson	

MEDICAL CERTIFICATION

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1 hour

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. This document will be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) Catherine Nuala Brennan						2a. DATE OF DEATH MONTH DAY YEAR 01 27 87		2b. HOUR 11:50am	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 26 39		6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS.		7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ireland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Baltimore Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY ---	
13a. STATE Maryland						13b. COUNTY Baltimore		13c. CITY OR TOWN Ruxton	
14. FATHER'S NAME FIRST MIDDLE LAST Vincent Deeney				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Clark					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 463-92-0670		17. INFORMANT ADDRESS Dr. M.J. Brennan 7811 Ellenham Avenue 21204			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO, OR AS A CONSEQUENCE OF (b) Hemolytic Anemia DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Gastric Cancer								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 5-6 weeks 2 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from January 11, 1987 to January 27, 1987, that (I) (we) last saw the deceased alive on January 27, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.									
22b. SIGNATURE Jacob L. Glock, M.D.						DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jacob L. Glock, M.D.						22e. ADDRESS G.B.M.C.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-31-87		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Lutherville Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home 6500 York Road 21212						25a. DATE REC'D. BY REGISTRAR FEB 4 1987		25b. REGISTRAR'S SIGNATURE Lisa Friedman-Purcell	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 00331

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Edward L. Brewster		1 13 87		4:30 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. BALTIMORE CITY OR COUNTY OF DEATH	
Male	White	8 14 1910	76	Baltimore County MD.	
7a. BIRTHPLACE	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Illinois	U.S.A.		Baltimore County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION	12a. USUAL OCCUPATION	12b. KIND OF BUSINESS OR INDUSTRY		
Towson	102 Judges Lane	Architect	Naval		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Maryland	Balto.	Towson	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	102 Judges La. 21204	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			
Walter S. Brewster	Kate Lancaster	Yes (YES, NO OR UNKNOWN) W.W.11			
16b. SOCIAL SECURITY NO.	17. INFORMANT	17. ADDRESS			
214-03-2294	Mrs. Margaret D. Brewster	Same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Cardiac Arrest					
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Arteriosclerosis					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) the hospital attended the deceased from 1/13/87 to 1/13/87, that (I) was saw the deceased alive on 1/13/87, and that in (my) last opinion death occurred on the date and hour and from the causes stated above, (I) was (did not) view the body after death.					
22b. SIGNATURE					
22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					
22e. ADDRESS					
Andrew Weinfeld M.D. 222 W. Coldspring La.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE	23e. DATE REC'D BY REGISTRAR	
Cremation	1/14/87	Westview Cemetery	Balto. Balto. Md.	21204	
24. FUNERAL DIRECTOR					
NAME ADDRESS					
Ruck Towson Funeral Home, Inc. 1050 York Rd.					

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8700338
REG. NO.

1- FOR
STATE
REGISTRAR

1- DECEASED NAME (TYPE OR PRINT) Cora Mary Brigerman			2a. DATE OF DEATH MONTH DAY YEAR 1 18 87			2b. HOUR 4:56 P	
3 SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 17, 1920		6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10 CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
14 FATHER'S NAME FIRST MIDDLE LAST Symon Drzymala				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maryanna Mardis			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-03-8549		17 INFORMANT ADDRESS Stephen Brigerman 8 Perhall Ct. 21236			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>out of lung with brain metastases</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 mos
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <u>Prostate adenitis, ASCD</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>Aug</u> 19 <u>87</u> to <u>Jan</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>1/16</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Arthur Serpick</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/19/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Arthur Serpick M.D.				22e. ADDRESS St. Joseph Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan 22 1987		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24 FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.				25a. DATE REC'D. BY REGISTRAR JAN 20		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DATE: 11/1/68

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042239 JAN 29 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit must be filed with the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "no", item 18 shows an injury or trauma. In such cases, the medical examiner must be notified of the death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
<div> <div>FOR STATE REGISTRAR</div> <div>87 00339 REG. NO.</div> </div>										
1. DECEASED NAME (TYPE OR PRINT) BROCKMEYER MICHAEL BROCKMEYER					2a. DATE OF DEATH MONTH DAY YEAR 1 25 87					2b. HOUR 10:08 PM
3. SEX m Male		4. RACE W White		5. DATE OF BIRTH MONTH DAY YEAR 12 12 26		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE Co. MD.				
12. CITY OR TOWN OF DEATH TOWSON, MD +		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST JOSEPH HOSPITAL				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Apalachian Council AFL-Cio		15. KIND OF BUSINESS OR INDUSTRY		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Maryland			16b. COUNTY Baltimore		16c. CITY OR TOWN Dundalk		16d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16e. STREET ADDRESS / ZIP CODE 3300 Sollers Point Rd. 21222	
17. FATHER'S NAME FIRST MIDDLE LAST Joseph J. Brockmeyer, Sr.					18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Hauck					
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			20. SOCIAL SECURITY NO. WW II 214-20-4606		21. INFORMANT ADDRESS Mary C. Brockmeyer 3300 Sollers Pt. Rd.					
<div> <div>19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____</div> <div>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 week</u></div> </div>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
22a. DATE OF OPERATION			22b. CONDITION FOR WHICH OPERATION WAS PERFORMED			22c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		22d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			23b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		23c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
24a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			24b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		24c. LOCATION STREET CITY OR TOWN COUNTY STATE					
25. I certify that (I) (this hospital) attended the deceased from <u>1/16</u> , 19 <u>87</u> , to <u>10-08 1/25</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10-08 1/25</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
26. SIGNATURE <u>Henry Fessler</u> MD					26b. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			26c. DATE SIGNED 1/25/87		
27. PHYSICIAN'S NAME (TYPE OR PRINT) HENRY FESSLER					27b. ADDRESS ST JOSEPH HOSPITAL, Towson, MD					
28a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		28b. DATE 1-29-87		28c. NAME OF CEMETERY OR CREMATORY Westview		28d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland				
29. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk 7922 Wise Ave. Dundalk, MD 21222					29b. DATE REC'D. BY REGISTRAR JAN 28 1987		29c. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

1

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (1))
20M 4 / B2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00340

FOR 1- STATE REGISTRAR		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR OF DEATH	
DECEASED NAME (TYPE OR PRINT)		JAMES		LAMBERT		BROWN, SR.		1		8		1987	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
Male		White		12 17 22		64		MONTHS		DAYS		1 8 1987	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH				MD.	
Maryland		U.S.A.		WIDOWED		DIVORCED		Baltimore County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Dundalk		1203 Ridgeshire Rd. 21222		Self Employed		Restaurant							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		Baltimore		Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1203 Ridgeshire rd. 21222					
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST			
Joseph		N.		Brown		Sarah		E.		Britt			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
Yes		WWII		219-05-1607		Margaret Miller 13 Liberty Pkwy 21222							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute intracerebral hemorrhage		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF									
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d)		Chronic hypertensive cardiovascular disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE J. Crossan O'Donovan		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER		DATE SIGNED 1/8/87							
EXAMINER'S NAME (TYPE OR PRINT) J. CROSSAN O'DONOVAN		ADDRESS 2112 DUNDALK AVE, BALTO, MD. 21222											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		1-12-87		Sacred Ht of Jesus		Dundalk Baltimore Maryland							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Duda-Ruck, Inc. 7922 Wise Ave. Balto Md 21222				JAN 12 1987		Julia Anderson-Randall							



J 40948 JAN 1988

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 00341
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) SAILE ELIZABETH BROWN			2a. DATE OF DEATH MONTH DAY YEAR January 13, 1987			2b. HOUR 12:23P M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 8, 1936		6. AGE (IN YEARS LAST BIRTHDAY) 50		7. IF UNDER 1 YEAR MONTHS DAYS YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Parkville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1714 Edgewood Road Apt A				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Finance Office		12b. KIND OF BUSINESS OR INDUSTRY Towson State Un.	
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Parkville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Francis J. Gavin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Saile Ellender			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 219-32-3376			17. INFORMANT ADDRESS Mr. Keith D. Brown same as # 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Breast Cancer								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 1/2 years	
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from May 1984 , to Jan-13, 1987 , that (I) (we) last saw the deceased alive on Dec-29, 1987 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Charles Padgett						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/14/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles Padgett, M.D.						22e. ADDRESS Good Samaritan Hospital Professional Bldg.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 1/14/87		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. 1050 York Road						25a. DATE REC'D. BY REGISTRAR JAN 16 1987		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been reviewed by the attending physician and completed, it is to be filled in by the funeral director. Page 3 should be stored for use as the burial-transit permit. These return papers, Pages 1 and 2, should be filed within 72 hours after death with the local health department, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any signs of or other traumatic event, the medical

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Teresa Anna Brown.						1 2 87		6:20 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
F. Female		Wh. White		MONTH DAY YEAR 4 13 93		93 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland SA.		USA				Balto. County, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Towson		Stella Maris Hospice				Home maker		-----	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Maryland		Baltimore		Overlea		13e. STREET ADDRESS / ZIP CODE 4719 Ridgeway Avenue 21206			
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Frank A. Fischer					Amelia Richter				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MD.					
NO		310-01-0903		Marjorie Ewers 9107 Maygall Rd. Perry Hall					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent Stroke</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Advanced Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
18a. DATE OF OPERATION		18b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE _____				DEGREE _____				22c. DATE SIGNED _____	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DR. Eddie NAKHODA</u>				22e. ADDRESS <u>Stella Maris Hospice, Towson, MD.</u>				22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>1/5/1986</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Most Holy Redeemer Cem</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore, MD.</u>			
24. FUNERAL DIRECTOR NAME ADDRESS <u>Dippel Funeral Homes, Inc. 7110 Belair Road Baltimore, MD 21206</u>						25a. DATE REC'D. BY REGISTRAR <u>JAN 6 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia S. ...</u>	

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RECEIVED
JAN 1 1961

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

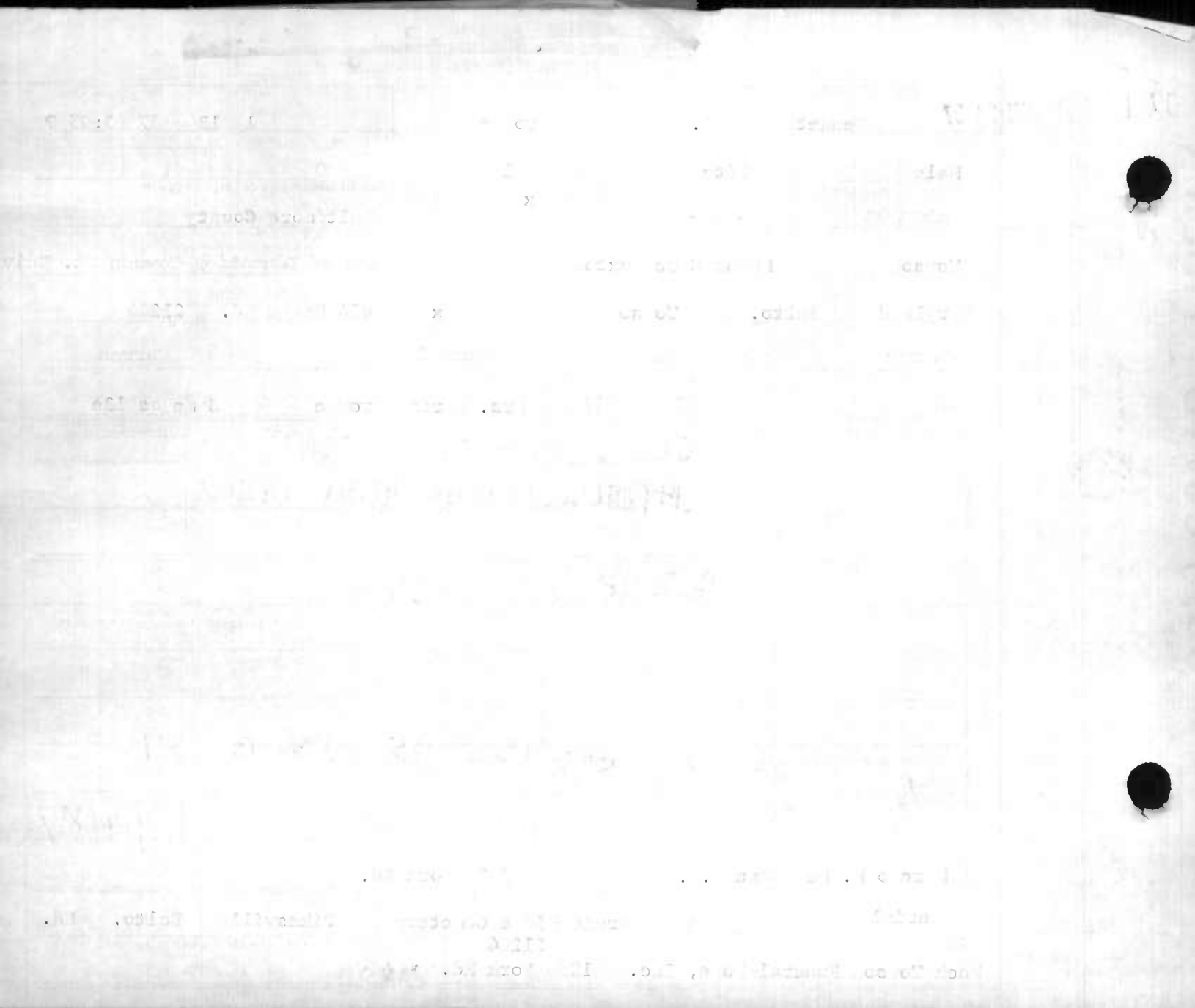
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the topcopper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				87 00343 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Kenneth A. Browne				2a. DATE OF DEATH MONTH DAY YEAR 1 13 87				2b. HOUR 3:05 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 1 06		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nebraska		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Ruxton				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dean of Education		12b. KIND OF BUSINESS OR INDUSTRY Towson St. Univ.			
13a. STATE Maryland				13b. COUNTY Balto.		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 414 Range Rd. 21204	
14. FATHER'S NAME FIRST MIDDLE LAST George N. R. Browne				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucretia Warren							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 339-28-4718		17. INFORMANT ADDRESS Mrs. Maria Browne Same as 13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO VASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ALZHEIMER'S DISEASE										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from OCT 13 19 75 to JAN 13 19 87, that (I) (we) last saw the deceased alive on JAN 9 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) saw the body after death.											
22b. SIGNATURE Marcio M. Menendez				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/14/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marcio M. Menendez M.D.				22e. ADDRESS 5820 York Rd.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-16-87		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville Balto. Md.					
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.				ADDRESS 1050 York Rd.		25a. DATE REC'D. BY REGISTRAR JAN 20		25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury or traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARIANNA Buchmann					2a. DATE OF DEATH MONTH DAY YEAR 1 21 87		2b. HOUR 5 ³⁰ M		
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 21 06		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. PLACE OF BIRTH (STATE OR FOREIGN COUNTRY) Md. Carroll County		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE County MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) EASTPOINT Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Hwf		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 500 Southview Ct. 21014	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Beam				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ola Raver					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-46-2173 212-22-3411		17. INFORMANT ADDRESS Mr. F. Glenn Buchman, Bel Air, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Central Pulmonary Failure								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immed	
DUE TO, OR AS A CONSEQUENCE OF (b) Multiple Cerebrovascular Accidents								4 yrs	
DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 10									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 12-19, 1983, to 1-21, 1987, that (I) (we) last saw the deceased alive on 1-20-1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE B. Little MD				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-21-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) . B. Little MD				22e. ADDRESS 1012 Old Northpoint Rd., Baltimore, Md. 21224					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-24-87		23c. NAME OF CEMETERY OR CREMATORY Wesley Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hampstead-Carroll Md.			
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md.				25a. DATE REC'D. BY REGISTRAR JAN 29 1987		25b. REGISTRAR'S SIGNATURE Julia Anderson			

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040012 JAN - 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

PAUL KARL

BUCHWALD SR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

67 00345

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Paul K. BUCHWALD			2a. DATE OF DEATH MONTH DAY YEAR January 4, 1987			2b. HOUR 11:47 A.M.				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 06 11 1914		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MACHINIST		12b. KIND OF BUSINESS OR INDUSTRY BETH. STEEL		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY BALTO		13c. CITY OR TOWN ROSEDALE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7908 31st ST 21237	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN E. BUCHWALD			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH --- GOETTE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) n/a		17. INFORMANT RUTH BUCHWALD		ADDRESS 7908 31st ST			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cor pulmonale</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery disease with MI</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u> <u>9 months</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Morbid Obesity</u>										
19a. DATE OF OPERATION NA			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NA			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) NA					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) NA		21f. LOCATION STREET CITY OR TOWN COUNTY STATE NA BALTO MD					
22a. I certify that (I) (this hospital) attended the deceased from <u>4/30/85</u> 19 <u>85</u> to <u>1/4/87</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9/4/86</u> 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above.										
22b. PHYSICIAN'S NAME (TYPE OR PRINT) ROSEMARY OLIVO MD			22c. DATE SIGNED 1/5/87			22d. ADDRESS 5444 BELAIR ROAD BALTO, MD 21206				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 1/07/87		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO --- MD			
24. FUNERAL DIRECTOR NAME J. Chesapeake			25a. DATE REC'D. BY REGISTRAR JAN 5 1987		25b. REGISTRAR'S SIGNATURE Julia Anderson-Randner					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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040156 JAN 18

UNKNOWN #87-2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 00340

1. DECEASED NAME (TYPE OR PRINT) ESTHER B. BURKHART			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1 4 19 87			2b. HOUR M													
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 3/12/15		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 4 19 87		7d. HOUR 7:12 P.M.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.							
10. CITY OR TOWN OF DEATH Chase				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Eastern Blvd. & Greenbank Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker				12b. KIND OF BUSINESS OR INDUSTRY Own Home							
13a. STATE PA				13b. COUNTY				13c. CITY OR TOWN Philadelphia				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 4 Oak Road, 19118			
14. FATHER'S NAME FIRST MIDDLE LAST Owen Oscar Brophy				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esther Call															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 171 32 3323				17. INFORMANT ADDRESS Jacob F. Ruth Funeral Home, PA											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR XXXX MONTH DAY YEAR 1:30 P.M. 1-4- 19 87				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Occupant of train/train collision.											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) railroad tracks				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Eastern Blvd. &, Chase Baltimore MD		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Greenbank Rd. Baltimore MD									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																			
ACTUAL SIGNATURE <i>Charles P. Kokes</i>				TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER				DATE SIGNED 1-5-87											
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.				ADDRESS 111 Penn St., Balto., MD 21201															
23a. BUIAL OR REMOVAL (SPECIFY) Removal - Burial				23b. DATE 1/7 /87		23c. NAME OF CEMETERY OR CREMATORY Holy Sepulcher				23d. LOCATION CITY OR TOWN COUNTY STATE Philadelphia, Montgomery Co., PA									
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co ADDRESS 4905 York Road Balto., MD 21212								25a. DATE REC'D. BY REGISTRAR JAN 7 1987		25b. REGISTRAR'S SIGNATURE <i>Julia T. Anderson-Randall</i>									

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 BP 999999

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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Home Office

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041816 JAN 28 1987

Film 6024 item 5

FOR
STATE 2/4/87 rja
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

67 00347

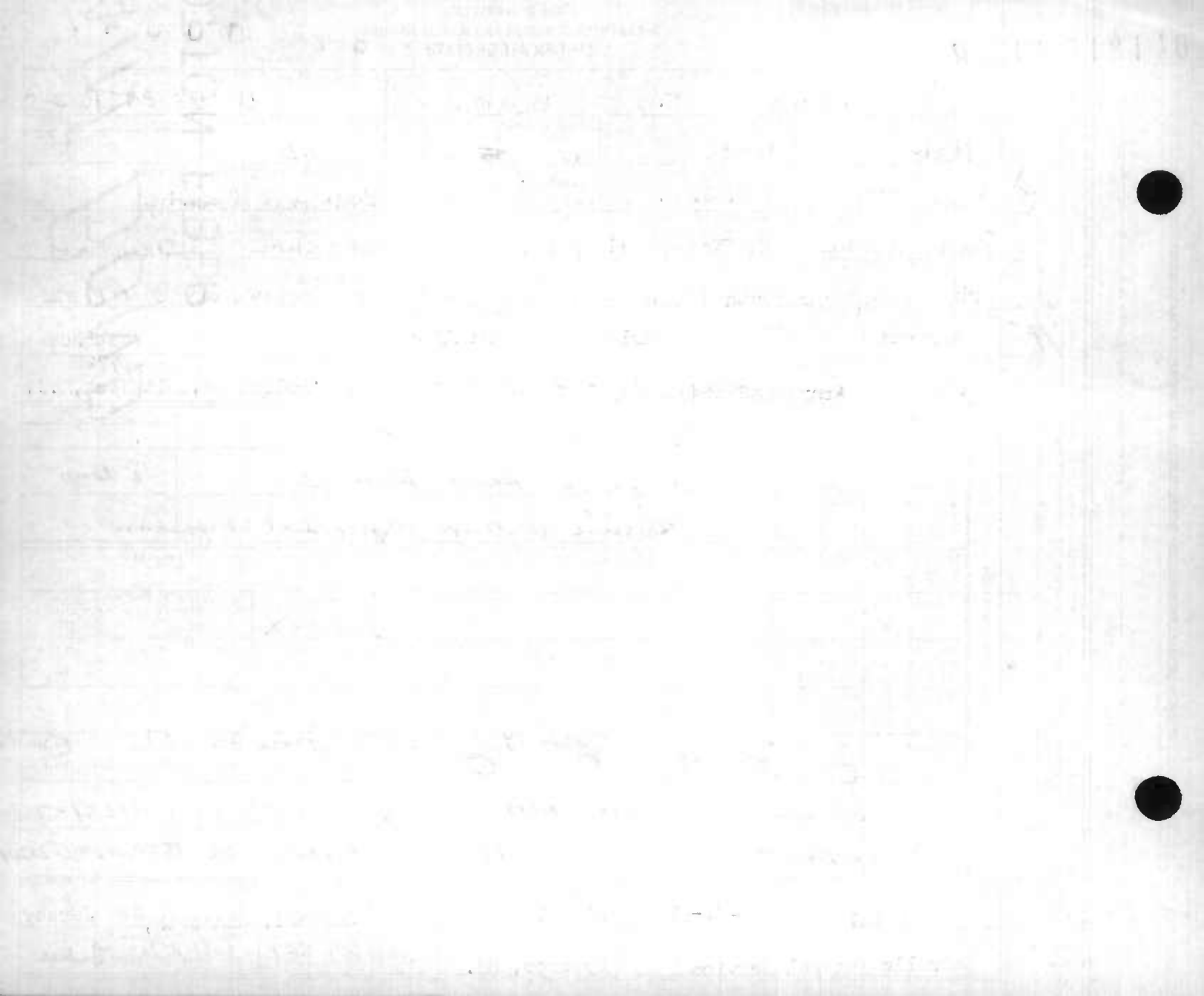
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William H. Burlew		2a. DATE OF DEATH MONTH DAY YEAR 01 23 87		2b. HOUR 10:20 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10 30 34		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD	
10. CITY OR TOWN OF DEATH Balto. County	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN	12b. KIND OF BUSINESS OR INDUSTRY INSURANCE
13a. STATE New Jersey		13b. COUNTY Monmouth	13c. CITY OR TOWN Colts Neck	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Bertram Burlew		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline Veebroeck		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATE) Army Peacetime 53-24-2108		17. INFORMANT ADDRESS 07722 Sharon Burlew 4 Woodhollow Rd. Colts Neck, N.J.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circumstantial Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Massive Anterior Myocardial Infarction</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>8 days</u>				
MEDICAL CERTIFICATION				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 14</u> , 19 <u>87</u> , to <u>Jan 23</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Jan 23</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did, did not) view the body after death.				
22b. SIGNATURE <u>Patricia A. Savadel</u>		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/23/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. SAVADEL		22e. ADDRESS 120 SR PIERRE DR TOWSON MD 21204		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1-26-87	23c. NAME OF CEMETERY OR CREMATORY Holmdel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Holmdel, Monmouth New Jersey
24. FUNERAL DIRECTOR NAME Marzullo Funeral Service		ADDRESS Upperco, Md.		25a. DATE REC'D BY REGISTRAR JAN 27 1987
		25b. REGISTRAR'S SIGNATURE <u>Julia Tindon-Rudell</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 00348
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Bessie B Burns			2a. DATE OF DEATH MONTH DAY YEAR 1-8-87			2b. HOUR M			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12-22-1887		6. AGE (IN YEARS LAST BIRTHDAY) 99 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Towson MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St Joseph Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md			13b. COUNTY		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Henry Noble			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Thompson			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 213-74-5732			17. INFORMANT ADDRESS FRANK BURNS 6010 PRESOTT AVE						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Severe Decubitus Ulcer, Sacrum DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Heating P. Dizon, M.D.			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1/8/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 1/12/87		23c. NAME OF CEMETERY OR CREMATORY St. Mary's of Assumption		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO md.		
24. FUNERAL DIRECTOR NAME CHARTMAN HARRIS			ADDRESS FN 1701 McCulloh St.			25a. DATE REC'D. BY REGISTRAR JAN 12 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

BP

01-01-01

RECEIVED
JAN 1 1961

01-01-01

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[The following text is extremely faint and largely illegible, appearing to be a memorandum or letter with several paragraphs.]

01-01-01



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101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
<div style="text-align: right;">8 7 0 0 3 4 9 REG. NO.</div>									
1- FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) Dorothy L. Burns					2a. DATE OF DEATH 1-26-87			2b. HOUR 11:59 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 4-26-1922		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. Co. MD.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Operator		12b. KIND OF BUSINESS OR INDUSTRY C&P AT&T	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5806 Edgepark Rd. 21239			
14. FATHER'S NAME FIRST MIDDLE LAST George Simpson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Davis				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-18-2910		17. INFORMANT ADDRESS Edward P. Burns, Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Small Cell Carcinoma, Lung, metastatic DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (this hospital) attended the deceased from 1/26/87 19 87 , to 1/26 19 87 , that (we) last saw the deceased alive on 1/26 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (do) (do not) view the body after death.									
22b. SIGNATURE Charles F. Hoesch, M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1/28/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles F. Hoesch, M.D.					22e. ADDRESS 9712 Belair Rd.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-30-87		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.			
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc., 5305 Harford Rd.					25a. DATE REC'D. BY REGISTRAR JAN 29 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 00350	
1- FOR STATE REGISTRAR						2a. DATE OF DEATH		MONTH DAY YEAR		7b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET CORA CALLAN						January 20, 1987				7:15 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		February 12, 1914		72 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Baltimore County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Catonsville		415 S. Rolling Road						Accounts Clerk		Retail	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		
Maryland			Baltimore		Woodlawn		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1506 Kirkwood Road 21207		
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Thomas Patrick Fahey				Mary Kelly							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No				215-09-5274		Patricia Callan		833 William Street Baltimore, MD. 21230			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Myeloma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
				HOUR A.M. MONTH DAY YEAR P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY		21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>83</u> to <u>Jan 20</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>Jan 19</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		22c. DATE SIGNED			
<u>Emile R Mokler Jr</u>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		1/20/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
EMILE R MOKLER JR						900 CATON AVE BALTO 21229					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE	
Burial				1/23/87		Woodlawn Cemetery		Woodlawn		Maryland	
24. FUNERAL DIRECTOR						25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, MD. 21228						JAN 28 1987		<u>Julia Denden-Randall</u>			

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041328 JAN 21 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 00351
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Margaret ELIZABETH Cameron			2a. DATE OF DEATH MONTH DAY YEAR 01-19-87		2b. HOUR 7:45a M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10-27-06 1906		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE STATE OR FOREIGN MARYLAND Baltimore	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dulaney Towson Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY	12b. KIND OF BUSINESS OR INDUSTRY MEDICINE	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE	13c. CITY OR TOWN RANDALLSTOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3 CASSANDRA COURT 21133
14. FATHER'S NAME FIRST MIDDLE LAST Oscar Quesnel		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Morningstar			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-36-1415		17. INFORMANT ADDRESS 21133 MARGARET E. JERMAIN RANDALLSTOWN, MD	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Pulmonary Disease</i> DUE TO, OR AS A CONSEQUENCE OF— Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>A.S.C.V. Disease</i> DUE TO, OR AS A CONSEQUENCE OF— (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Pulmonary Emphysema & Pulmonary Stenosis</i>		
19a. DATE OF OPERATION	19b. OPERATION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (was hospital) attended the deceased from <i>12-10-</i> 19 <i>86</i> , to <i>1-19-</i> 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>1-19-</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		
22b. SIGNATURE <i>Bernard S. Karpers Jr. M.D.</i>	DEGREE	22c. DATE SIGNED <i>1-19-87</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Bernard S. Karpers Jr., MD</i>	22e. ADDRESS <i>107 PROFESSIONAL ARTS BLDG 101 W. READ ST. BALTO. MD. 21204</i>	

23a. BURIAL, CREMATION, REMOVAL BURY	23b. DATE JAN. 20, '87	23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CO., MD
24. FUNERAL DIRECTOR NAME ADDRESS WILLIAM E. JOHNSON 8521 LOCH RAVEN BLVD.		25a. DATE REC'D BY REGISTRAR JAN 19 1987	25b. REGISTRAR'S SIGNATURE <i>Julia</i>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon copies. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked as item 21a or 21b, or if any injury, or other traumatic event, the medical examiner should be notified.

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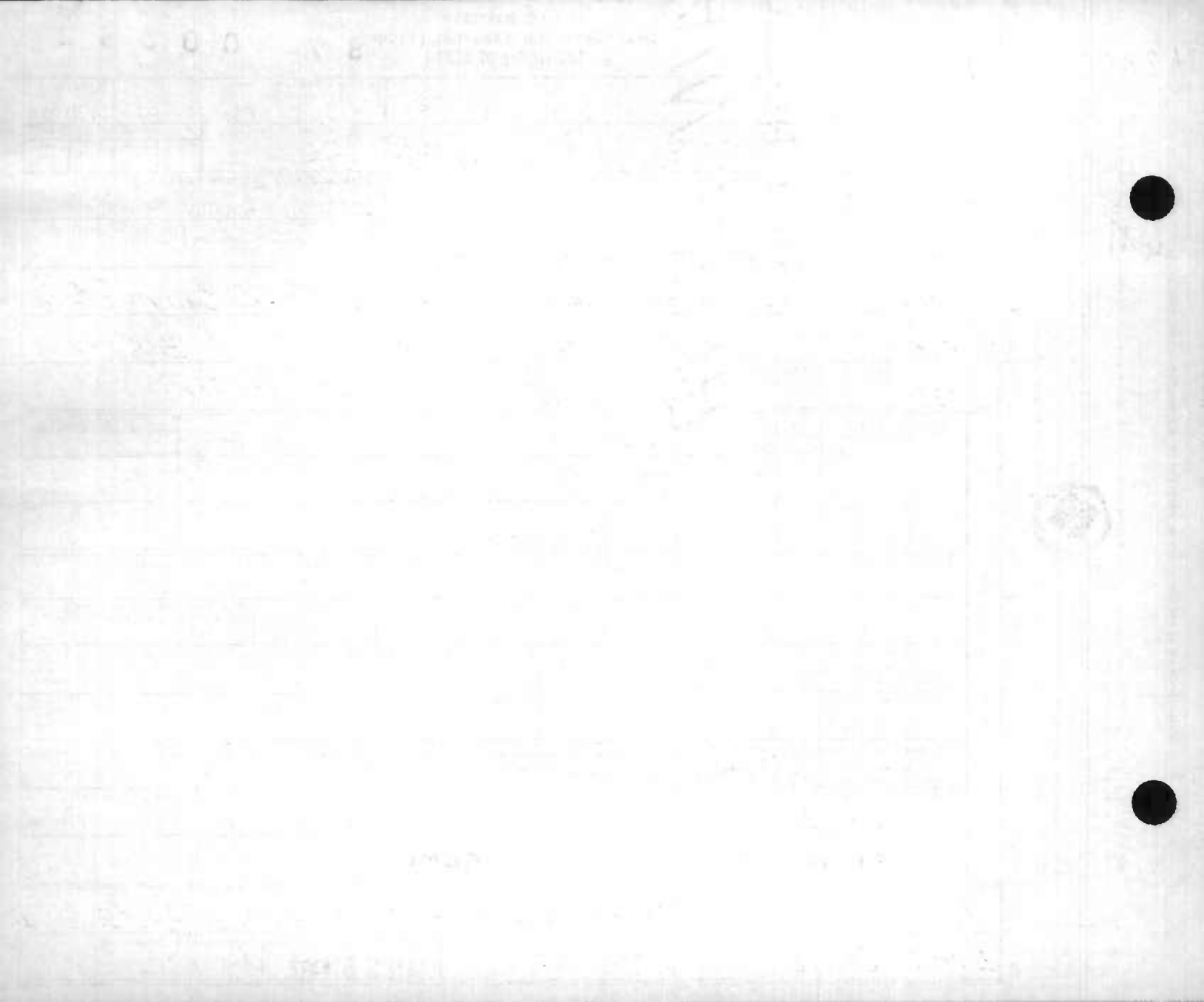
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then it must be filed with the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or a medical examiner must be notified of a traumatic event, the medical examiner must be notified of the event.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) Gordon D. Campitelli, JR.					2a. DATE OF DEATH MONTH DAY YEAR 01 22 87			2b. HOUR 1:20 p.m.		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 29, 1934		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS.		7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO. MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Baltimore Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.					13b. COUNTY BALTO. CO.		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST GORDON D. CAMPITELLI, SR.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIAN - BISESI					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-30-0398		17. INFORMANT ADDRESS FAMILY RECORDS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bronchogenic Adenocarcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>History of osteosarcoma</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>January 8, 1987</u> to <u>January 22, 1987</u> , that (I) (we) last saw the deceased alive on <u>January 22, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Vik Poonai					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VIK POONAI					22e. ADDRESS GBMC					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 1-27-1987		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION (CITY OR TOWN) COUNTY STATE ROSEDALE BALTO. CO. MD.			
24. FUNERAL DIRECTOR EVANS CHAPEL OF MEMORIES					25a. DATE RECD. BY REGISTRAR JAN 28 1987		25b. REGISTRAR'S SIGNATURE A. J. Friedman-Pandora			



14 0003 JAN - 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 00353

1. DECEASED NAME (TYPE OR PRINT) Rita M. Carlotta			2a. DATE OF DEATH MONTH DAY YEAR January 2, 1987		2b. HOUR 10:07 AM
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR 2-5-1929	6 AGE (IN YEARS LAST BIRTHDAY) 57 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD		
10. CITY OR TOWN OF DEATH Rossville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md.	13b. COUNTY Balto.	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5644 Hughes La. 21220	
14. FATHER'S NAME FIRST MIDDLE LAST Rock Scola		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary D'Alessandro			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 215-24-8679		17. INFORMANT ADDRESS Frank P. Carlotta, Sr., Same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic lung carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>S. Milner</i>		DEGREE M.D.		22c. DATE SIGNED 1/3/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sheldon D. Milner, M.D.		22e. ADDRESS 406 Eastern Blvd.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-5-87		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	
23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.					
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc., 5305 Harford Rd.			25a. DATE REC'D. BY REGISTRAR JAN 5 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

• 516 •

040582 JAN

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOSEPH HILLARD CARRICK			2a. DATE OF DEATH MONTH DAY YEAR 1-9-87			2b. HOUR 5P M				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUG. 14, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY, MD.				
12. CITY OR TOWN OF DEATH 21234		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8518 CHESTNUT OAK RD. 21234				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PAINTER		15. KIND OF BUSINESS OR INDUSTRY HOMES		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE MARYLAND			16b. CITY OR TOWN BALTIMORE		16c. CITY OR TOWN 21234		16d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16e. STREET ADDRESS / ZIP CODE 8518 CHESTNUT OAK RD. 21234	
17. FATHER'S NAME FIRST MIDDLE LAST WILLIAM E. CARRICK			18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARION							
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			19b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-07-1612		20. INFORMANT DENNIS M. LARKIN		20a. ADDRESS 21234 8518 CHESTNUT OAK RD.			
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CHRONIC OBS. AIRWAYS DISEASE; BULLOUS EMPHYSEMA										
21a. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			22b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR NOV 19 80			22c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
22d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			22e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			22f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22g. I certify that (1) (this hospital) attended the deceased from NOV 19 80 to JAN 9 87 , that (1) (we) lost the deceased on SEP 19 86 , and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.										
22h. SIGNATURE J. DAVID NAGER, M.D.			22i. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22j. DATE SIGNED JAN 12 1987				
22k. PHYSICIAN'S NAME (TYPE OR PRINT)			22l. ADDRESS 1205 YORK RD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE JAN. 13, '87		23c. NAME OF CEMETERY OR CREMATORY ST. STEPHENS CHURCH		23d. LOCATION CITY OR TOWN COUNTY STATE BRADSHAW, MARYLAND			
24. FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON			24a. ADDRESS 8521 LOCH RAVEN BLVD			24b. DATE REC'D. BY REGISTRAR JAN 12 1987		24c. REGISTRAR'S SIGNATURE Julia Gordon		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
JAMES EDWARD CARROLL			January 28, 1987			9 P M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS		
Male	White	February 3, 1912	74 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	U.S.A.		Baltimore County MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Catonsville	106 Maiden Choice Lane		Dispatcher			American Brewery		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. CITY OR TOWN			13c. STREET ADDRESS / ZIP CODE		
Maryland			Baltimore			106 Maiden Choice Lane 21228		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
James P. Carroll			Mary Agnes Murphy					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT ADDRESS		
Yes			WW II			Dorothy Hilton 7 Arkla Court Baltimore, MD. 21228		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carsona of lung</i> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from <i>2/2/87</i> , 19 <i>83</i> , to <i>Jan 28</i> , 19 <i>87</i> , that (1) (we) lost saw the deceased alive on <i>1-19</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Charles R. Graham</i>			DEGREE no			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>1/29/87</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
Charles R. Graham M.D.			299 Frederick Road, Baltimore, MD. 21228					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial			2/2/87		New Cathedral Cemetery		Baltimore Maryland	
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, MD. 21228					25a. DATE REGD. BY REGISTRAR FEB 3 1987		25b. REGISTRAR'S SIGNATURE <i>James W. Anderson-Randall</i>	

BP

2008 COTTON FIBER

040738 JAN 16 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 00356

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Elizabeth Carter			2a. DATE OF DEATH MONTH DAY YEAR January 12, 1987			2b. HOUR 11:50 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 22 1898		6. AGE (IN YEARS LAST BIRTHDAY) 88		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) Kentucky		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Middle River 21220		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1105 Fuselage Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Middle River		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 1105 Fuselage Ave. 21220			14. FATHER'S NAME FIRST MIDDLE LAST Joe Caudill			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sally Cambell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214 22 6427		17. INFORMANT 33 Gyro Drive Balto. Md. 21220		18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest - DUE TO, OR AS A CONSEQUENCE OF (b) ASCVDC aurricula fibrillation DUE TO, OR AS A CONSEQUENCE OF (c) ASCVDC Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 10 1) COPD 2) Pernicious anemia									
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from June 19 61 to Jan 19 87 , that (2) (I) saw the deceased alive Jan 19 87 , and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (2) (3) (did not view the body after death)									
22b. SIGNATURE Charles M. Kerr MD DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles M. Kerr MD				22e. ADDRESS 6801 Belvoir Rd 21206					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 1/16/87		23c. NAME OF CEMETERY OR CREMATORY American Legion Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Big Stone, Va.			
24. FUNERAL DIRECTOR NAME Eruzdzinski Funeral Home PA 1407 Old Eastern Ave				25a. DATE REC'D. BY REGISTRAR JAN 13 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Pedraza			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

Elizabeth Carter

January 12, 1900

Female

White

March 27 1898

88

Kentucky

USA

xx

Bellevue County

Mobile River 21220

1102 Swanton Ave.

Housewife

xx 1102 Swanton Ave. 21220

Don Carroll

21220 1102 Swanton Ave. 21220
also 1102 Swanton Ave. 21220

1102 Swanton Ave. 21220

Don Carroll

1102 Swanton Ave. 21220

DHMM - 17
(VR A15 ME (5))

17 NOV 1950



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GLORIA CHAPLIN			2a. DATE OF DEATH MONTH DAY YEAR HOUR 01 21 87 235 P.M.		
3 SEX F	4 RACE B	5. DATE OF BIRTH MONTH DAY YEAR 7 25 28	6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Balto. County MD		
10. CITY OR TOWN OF DEATH Balto. Co.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balto. Co. General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Babysitter		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Balto. 13c. CITY OR TOWN Balto.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 7103 Walnut Ave. 21208		
14. FATHER'S NAME FIRST MIDDLE LAST William Purnell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Geman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 213-26-0617		17. INFORMANT ADDRESS Rayfield Wright 7103 Walnut Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) sepsis DUE TO, OR AS A CONSEQUENCE OF (b) lung Abscess. DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Alcoholism PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (d) Oxygen disorders @ pneumonia					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) (this hospital) attended the deceased from 12-24-1987 to 01-21-1987 that (a) (we) last saw the deceased alive on 01-21-1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death)					
22b. SIGNATURE m. E. WOUR		DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 01-21-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) m. E. WOUR		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/28/87		23c. NAME OF CEMETERY OR CREMATORY Balto. Nat.	
23d. LOCATION CITY OR TOWN COUNTY STATE Balto. MD		24. FUNERAL DIRECTOR NAME ADDRESS March F/H 1101 E. North Ave.			
25a. DATE REC'D. BY REGISTRAR JAN 28 1987		25b. REGISTRAR'S SIGNATURE John Linton Radtke			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages found 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

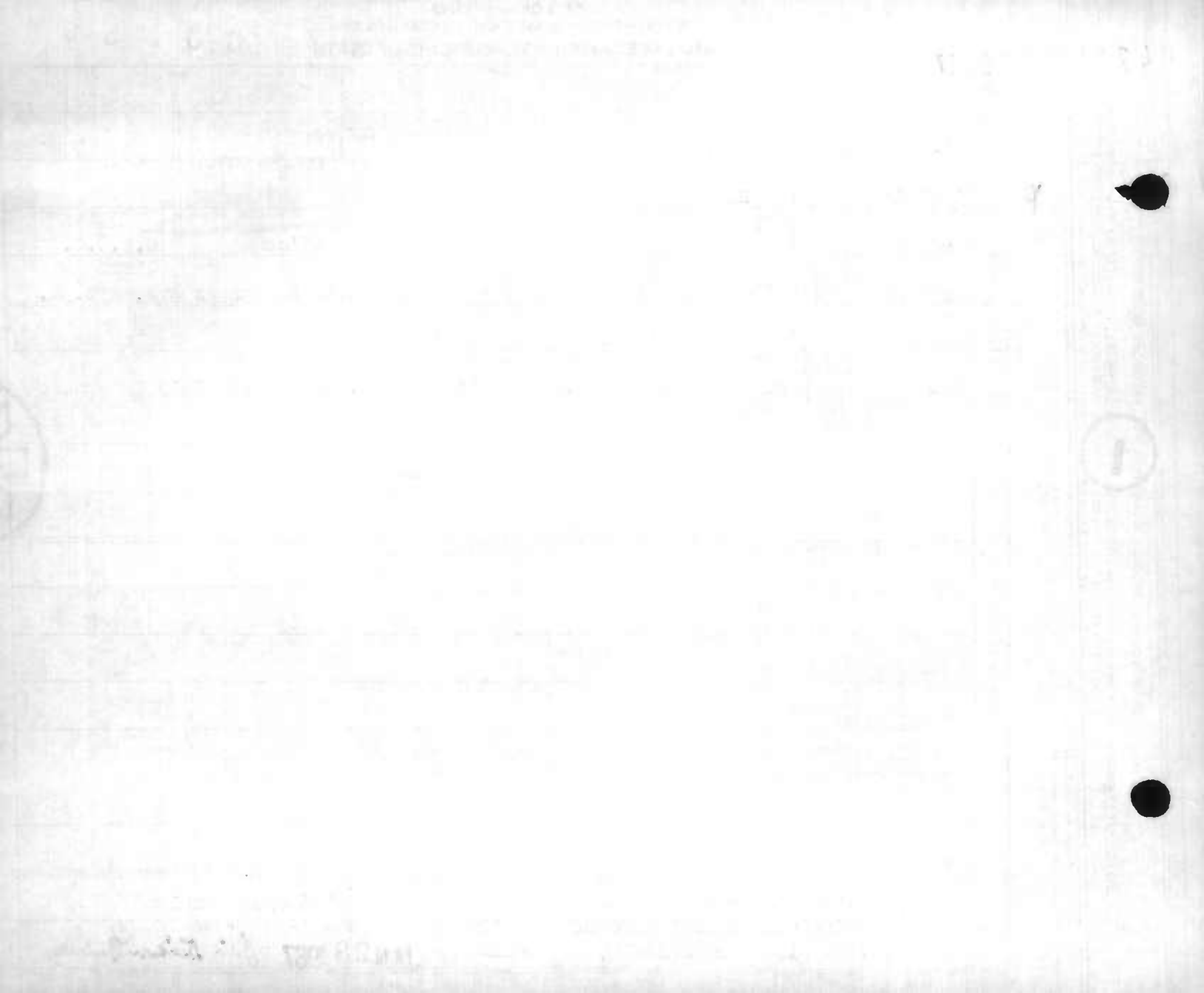
REG. NO. 00359

1- FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	7a. DATE KNOWN OF DEATH ESTI- MATED		MONTH	DAY	YEAR	7b. HOUR	
		James Robert Childress					<input checked="" type="checkbox"/> 1 22 19 87					M	
3 SEX	4. RACE	5. DATE OF BIRTH		MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN.
Male	White	9 27 25		61	65	YRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Virginia		USA				Baltimore County MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Dundalk		919 Wise Avenue		Police		S.P.C.C.							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		21222			
Maryland		Baltimore		Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1613 Inverness Ave. Apt. B.					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
Unknown		Childress		Lilliam Poole		Yes		WW II		216-12-8366		Elizabeth S. Childress 1613 Inverness Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF													
DUE TO, OR AS A CONSEQUENCE OF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		1/23/87							
EXAMINER'S NAME (TYPE OR PRINT)		William M. Zane, M.D.		ADDRESS		111 Penn St. Balto. MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Cremation		1-23-87		Westview		Baltimore, Maryland							
24. FUNERAL DIRECTOR NAME		Duda-Ruck Funeral Home of Dundalk		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
7922 Wise Ave Dundalk, MD 21222		JAN 28 1987		Julia S. S. S. S. S.									

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXCLUDE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM "M" 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. The certificate should be retained by the funeral director and filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any indication of a traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 00360			
1. DECEASED NAME (TYPE OR PRINT) Jawet Elizabeth Ciampaglio			2a. DATE OF DEATH MONTH DAY YEAR 1 9 87			2b. HOUR 3:05 AM							
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 11 14 43		6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. MD.							
10. CITY OR TOWN OF DEATH Baltimore Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St Joseph Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Alcohol Control		12b. KIND OF BUSINESS OR INDUSTRY State of Md.					
13a. STATE MD				13b. COUNTY Fallston		13c. CITY OR TOWN Fallston		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2022 Fallsgrove Wy 21047			
14. FATHER'S NAME FIRST MIDDLE LAST Alfred M. Feathers Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary H. Silipote									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 24-40-1233		17. INFORMANT Mr. Paul R. Ciampaglio				ADDRESS Same					
18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardio-Respiratory unknown etiology DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Breast Ca. recurrent DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Kidney Disease CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 8-12-86 to 1-9-87, that (I) (we) last saw the deceased alive on 1-9-87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not know the body after death.													
22b. SIGNATURE [Signature]				22c. DATE SIGNED				22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sami A. Brahim MD FACP, FACP 7620 York Road Towson Md 21204					
22e. ADDRESS				22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE Jan. 12, 1987		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville Balto. Md.							
24. FUNERAL DIRECTOR NAME Leonard J. Ruck Inc. Baltimore, Maryland						25a. DATE REC'D. BY REGISTRAR JAN 12 1987		25b. REGISTRAR'S SIGNATURE Julia Anderson-Rudner					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low required ~~inmate~~ death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Death certificate ~~may~~ ^{may} be carbon-copied. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified ~~immediately~~ ^{immediately}.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 00361 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Francis Cianci						2a. DATE OF DEATH MONTH DAY YEAR January 28, 1987			2b. HOUR M M		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 3 7 06		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		IF UNDER 1 YEAR MONTHS DAYS 0 0		IF UNDER 24 HRS HOURS MIN. 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Owings Mills		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10119 Barnes Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Cab driver		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Owings Mills		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10134 Barnes Ave. 21117		
14. FATHER'S NAME FIRST MIDDLE LAST Santi J. Cianci				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Salvatora Taburo							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT Owings Mills ADDRESS MD 21117		Mrs. Vicky Kunkel 4941 Wards Chapel Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma liver</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12-5 19 86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12-5</u> , 19 <u>86</u> , to <u>1-28</u> , 19 <u>87</u> , that (I) (we) ^(we) lost saw the deceased alive on <u>1-20</u> , 19 <u>87</u> , and that in (my) (our) ^(our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) ^(we) (did) ^(did) not view the body after death.											
22b. SIGNATURE <u>C.E. McWilliam M.D.</u>						DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1-28-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>C.E. McWilliam M.D.</u>						22e. ADDRESS <u>1190A Kensington Rd. Kensington Md. 21136</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-30-87		23c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Gamber Carroll MD			
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc.						24b. ADDRESS 8728 Liberty Rd. Randallstown, MD 21133					
24c. DATE RECD. BY REGISTRAR FEB 03 1987						24d. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return all other pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or any traumatic event, immediate explanation must be filled in above.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William J. Cianferano			2a. DATE OF DEATH MONTH DAY YEAR January 20, 1987		2b. HOUR 3:01 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR January 7, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Randallstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General(DOA)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pressman		12b. KIND OF BUSINESS OR INDUSTRY Printing
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md 13b COUNTY -- 13c CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4454 La Plata Avenue 21211
14. FATHER'S NAME FIRST MIDDLE LAST Alfredo Cianferano			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Matilda Tounarill		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (EXCEPT FOR WAR OR DATES) WW11 215 01 3319		17. INFORMANT ADDRESS Reisterstown, Md. Carol J. Bolander 1030 Kingsbury Rd 21136	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from April 19 78 , to January 19 87 , that (I) (we) last saw the deceased alive on January 2, 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Francis X. Carmody		DEGREE MD		22c. DATE SIGNED 1/21/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Francis X. Carmody		22e. ADDRESS 201 E. University Parkway Union Memorial			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/23/87		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn, Balto. Co. Md.					
24. FUNERAL DIRECTOR NAME Burgee-Henss Funeral Home, 3631 Falls Rd 21211		25a. DATE REC'D. BY REGISTRAR JAN 28 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 00363
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Valentine A. CIOEFF			2a. DATE OF DEATH MONTH DAY YEAR January 7, 1987		2b. HOUR 12:45AM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR APR 26, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH ROSDALE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CRANE	12b. KIND OF BUSINESS OR INDUSTRY BETH STEEL	
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Parkville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 30211 CALIFORNIA AVE. 21234	
14. FATHER'S NAME FIRST MIDDLE LAST VALANTINE J. CIOEFF		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JACOBENA ARCH			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215 03 7981	17. INFORMANT ADDRESS FAMILY RECORDS			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Acute Myocardial Infarction of
Posterior WallAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b) Aspiration Pneumonia

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (we) this hospital) attended the deceased from December 27, 1987 to January 7, 1987, that (we) last saw the deceased alive on January 7, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.			
22b. SIGNATURE C. Ortel	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 1-7-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. Ortel M.D.		22e. ADDRESS 9000 Franklin Square Drive 21237	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 1-9-1987	23c. NAME OF CEMETERY OR CREMATORY Parkwood CSM	23d. LOCATION CITY OR TOWN COUNTY STATE Parkville BALTO MD.
24. FUNERAL DIRECTOR NAME EVANS CHARLOTTE MEMORIES HARFORD		25a. DATE REC'D. BY REGISTRAR JAN 8 1987	25b. REGISTRAR'S SIGNATURE Julia Davidson-Pudenz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please return your completed pages. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMM - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please enclose certain papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR 1a. DECEASED NAME (TYPE OR PRINT) Manily Mason Claggett									
2a. DATE OF DEATH MONTH January DAY 25 YEAR 1987									
3. SEX Male									
4. RACE Caucasian									
5. DATE OF BIRTH MONTH May DAY 3 YEAR 1900									
6. AGE (IN YEARS LAST BIRTHDAY) 86									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland									
7b. CITIZEN OF WHAT COUNTRY? U.S.A.									
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>									
9. BALTIMORE CITY OR COUNTY OF DEATH BALTO County MD.									
10. CITY OR TOWN OF DEATH Randallstown									
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital									
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter and									
12b. KIND OF BUSINESS OR INDUSTRY Farmer /retired									
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13b. STATE Maryland									
13c. CITY OR TOWN Baltimore									
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
13e. STREET ADDRESS / ZIP CODE 3700 Burmont Avenue 21133									
14. FATHER'S NAME FIRST Harmon MIDDLE Claggett LAST									
15. MOTHER'S MAIDEN NAME FIRST Unknown MIDDLE LAST									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no									
16b. SOCIAL SECURITY NO. 212-05-6251									
17. INFIRMITY ADDRESS Mrs. Linda Riley 21133 3700 Burmont Avenue Randallstown Maryland									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)									
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK									
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)									
21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 1-25-1987 to 1-25-1987 that (I) (we) lost saw the deceased alive on 1-25-1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Allen J. Chincus M.D. DEGREE									
22c. DATE SIGNED 1-25-87									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Allen J. Chincus M.D.									
22e. ADDRESS Balt. Co General Hosp.									
23a. BURIAL, CREMATION, REMOVAL Burial									
23b. DATE 1/28/87									
23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial Park									
23d. LOCATION Sykesville Carroll Maryland									
24. FUNERAL DIRECTOR NAME 8728 Liberty Road Randallstown, MD 21133 Loring Byers Funeral Directors, Inc.									
25a. DATE RECEIVED BY REGISTRAR JAN 27 1987									
25b. REGISTRAR'S SIGNATURE J. [Signature]									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 00305
REG. NO.

FOR
1- STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARIE V. CLARK		2a. DATE OF DEATH MONTH DAY YEAR 01 28 87		2b. HOUR 3:45a M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 20 1928		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC-6701 N. CHARLES ST.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife.	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY Balto.	13c. CITY OR TOWN Essex	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> *
14. FATHER'S NAME FIRST MIDDLE LAST Charles Carter		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Thelma Dickerhoff		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 276-24-2178		17. INFORMANT ADDRESS Sherman Clark 614 Middlesex Rd. 21221
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RENAL FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>RECURRENT CERVICAL CANCER</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11/86
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>ANEMIA/BOWEL OBSTRUCTION</u>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (I) (this hospital) attended the deceased from <u>12/28</u> 19 <u>86</u> , to <u>01/28</u> 19 <u>87</u> that (I) (we) lost saw the deceased alive on <u>01/28</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>Lisa Rubin</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LISA RUBIN, M.D.		22e. ADDRESS GBMC-6701 N. CHARLES ST.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/30/87	23c. NAME OF CEMETERY OR CREMATORY Holly Hill Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Middle River Balto. Md.	
24. FUNERAL DIRECTOR NAME Connelly Funeral Home		ADDRESS 300 Mace Ave. 21221		25a. DATE REC'D. BY REGISTRAR FEB 4 1987
		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>		

100840

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040443 JAN

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSITMENT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REC'D NO. 00360			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES M. CLAY										20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 1 4 19 87			
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 28 1953	6. AGE (IN YEARS) (LAST BIRTHDAY) 33 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD 1 5 19 87		24. HOUR 4:38A					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD							
10. CITY OR TOWN OF DEATH Chase		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Eastern Blvd. & Greenbank Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electronics Tech.		12b. KIND OF BUSINESS OR INDUSTRY Electronic					
13a. STATE Ct.		13b. COUNTY -		13c. CITY OR TOWN Vernon		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 60-C Mt. Vernon St. 06066					
14. FATHER'S NAME FIRST MIDDLE LAST E. James Clay, Jr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Felder				ADDRESS 1834 York Dr. Columbia, S.C.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 251-96-5884		17. INFORMANT Mary Clay (mother)		29204							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compression asphyxia</u> 8001 Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOURS MONTH DAY YEAR 1:30 P.M. 1-4- 19 87				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Occupant of train/train collision.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) railroad tracks				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Eastern Blvd. &, Chase, Baltimore MD Greenbank Rd.					
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>Margie Ore Krell</u>						TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER			DATE SIGNED 1-5-87				
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.						ADDRESS 111 Penn St., Balto., MD 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal				23b. DATE 1/6/87		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Columbia, Richland Co. SC			
24. FUNERAL DIRECTOR NAME Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213						25a. DATE REC'D. BY REGISTRAR JAN 9 1987			25b. REGISTRAR'S SIGNATURE <u>Julia Benson-Randall</u>				

07/84
RSM

BP

DHMH 17
FVR 15 ME (5)

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

#18a, 22a., G-625, Med. Ex.
FOR
1- STATE 3/6/87, Gbjj.,
REGISTRAR Part II.,

REG. NO. 00301

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HENRY CLAYMAN		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 29 1987		2b. HOUR M 10:15 A.M.
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR MAY 24, 1919	6. AGE (IN YEARS) LAST BIRTHDAY 67 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 29 1987		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore Co. General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TEACHER
12b. KIND OF BUSINESS OR INDUSTRY SCHOOLS		13a. STREET ADDRESS 3720 BRENBROOK DR. #21133		
13b. COUNTY BALTO.		13c. CITY OR TOWN RANDALLSTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST BENJAMIN CLAYMAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA ASTRIN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 216-07-7347		17. INFORMANT ADDRESS MRS. ETHEL CLAYMAN
16c. (IF YES, GIVE WAR OR DATES) WWII-ARMY		17. INFORMANT ADDRESS 3720 BRENBROOK DR. RANDALLSTOWN, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>Arteriosclerotic cardiovascular disease</u>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE <u>William M. Zane</u>		TITLE (SPECIFY) M.D. <u>Assistant</u> MEDICAL EXAMINER		DATE SIGNED <u>1-30-87</u>
EXAMINER'S NAME (TYPE OR PRINT) <u>William M. Zane, M.D.</u>		ADDRESS <u>111 Penn St., Balto., MD 21201</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE FEB. 1, 1987	23c. NAME OF CEMETERY OR CREMATORY BETH TFILOH	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.		25a. DATE REC'D. BY REGISTRAR FEB 5 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>
6010 REISTERSTOWN RD. BALTO., MD 21215				

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED FOR BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



043545 FEB

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

00368

1 - FOR
STATE
REGISTRAR

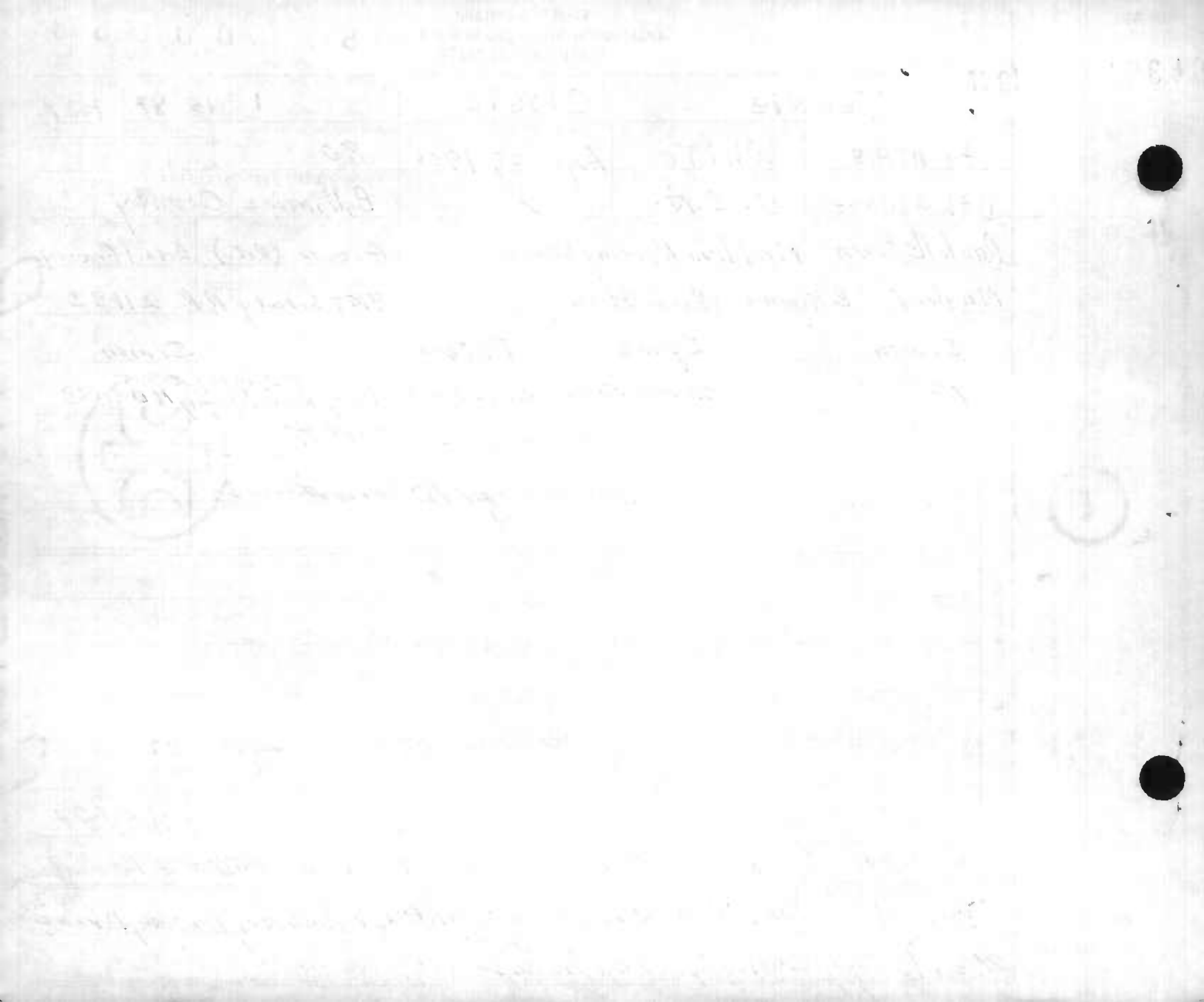
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Jennie		MIDDLE Closic		LAST Closic		20. DATE OF DEATH MONTH DAY YEAR 1 15 87.		20. HOUR 7:10 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 27, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DELAWARE		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD					
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Grocer (Ret.)		12b. KIND OF BUSINESS OR INDUSTRY Retail Groceries					
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9109 Liberty Rd 21133			
14. FATHER'S NAME FIRST MIDDLE LAST Simon Spive		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esther Simon.									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 222-20-5376		17. INFORMANT Joseph Mark K Closic		ADDRESS 8 Calgary Court Randallstown, MD 21133					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery arrest.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized arteriosclerosis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>December 19, 85</u> to <u>January 15, 1987</u> , that (I) (we) last saw the deceased alive on <u>1/11/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>R. Reider</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/15/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RUBEN REIDER		22e. ADDRESS M.D. 7445 FURNACE BRANCH Rd Glen Burnie									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 18/1987		23c. NAME OF CEMETERY OR CREMATORY Jewish Community Center (OKS)		23d. LOCATION CITY OR TOWN COUNTY STATE Wilmetton, Newcastle, Delaware					
24. FUNERAL DIRECTOR NAME Ala. Shuter		ADDRESS 519 Philadelphia Pike, Newington, DE		25a. DATE REC'D. BY REGISTRAR FEB 06 1987		25b. REGISTRAR'S SIGNATURE John F. ...					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be examined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicians and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please attach this certificate to the permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 (poison, injury, or other significant event), the medical examiner must be notified at once.



040911 JAN 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 00369

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <i>Mary Catherine Cohoe</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>1/8/87</i>			2b. HOUR <i>4A</i> M.					
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>12 7 02</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>84</i> YRS.		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		9b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Balto. City</i> MD.					
10 CITY OR TOWN OF DEATH <i>Balto.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>100 W. Univ. Pkwy.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Teacher</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <i>Md.</i>			13b. COUNTY		13c. CITY OR TOWN <i>Balto.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>100 W. Univ. Pkwy. 21210</i>		
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. <i>216-22-3572</i>			17. INFORMANT			ADDRESS		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>athero sclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i> <i>10 yrs</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. <i>diabetes m. adult onset</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>12/15/86</i> to <i>1/8/87</i> , that (I) (we) last saw the deceased alive on <i>12/15/86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) sign the death after death.											
22b. SIGNATURE <i>William F. Reuter</i>						22c. DATE SIGNED <i>1/8/87</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>William F. Reuter</i>						22e. ADDRESS <i>3222 St Paul St</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>			23b. DATE <i>1-8-87</i>			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
24 FUNERAL DIRECTOR NAME <i>Anatomy Board</i>						25a. DATE REC'D. BY REGISTRAR <i>JAN 14 1987</i>			25b. REGISTRAR'S SIGNATURE <i>Wm. Reuter</i>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by a attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return all 4 pages to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) REBECCA		FIRST MIDDLE LAST COHEN		2a DATE OF DEATH MONTH DAY YEAR JANUARY 22 1987		2b HOUR 130 P	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 2/26/1898		6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS	
7a BIRTHPLACE (STATE OR FOREIGN) MARYLAND		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTO. COUNTY MD	
10 CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTO. CO. GEN. HOSP.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MERCHANT		12b KIND OF BUSINESS OR INDUSTRY RETAIL	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND		13b COUNTY CARROLL		13c CITY OR TOWN ELDERSBURG		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST WILLIAM LAHN		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE UNKNOWN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b SOCIAL SECURITY NO. 215-32-7369D		17. INFORMANT MISS IDA COHEN ADDRESS 6203 LONG MEADOW DR. ELDBERSBURG, MD 21784					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ELECTROLYTE IN BALANCE DUE TO, OR AS A CONSEQUENCE OF (c) SEVERE DEHYDRATION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: COLOSTOMY & CONGESTIVE HEART FAILURE							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from DEC 1986 to JAN 22 1987 , that (I) (we) last saw the deceased alive on JAN 22 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22a SIGNATURE Ramon S. Pimentel, MD				DEGREE MD		22c DATE SIGNED JAN 22 1987	
22b PHYSICIAN'S NAME (TYPE OR PRINT) RAMON S. PIMENTEL				22e ADDRESS 7501 LIBERTY ROAD BALTO. 21207			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE JAN. 25, 1987		23c NAME OF CEMETERY OR CREMATORY BETH JACOB ANSHE VESHEAR ROSEDALE		23d LOCATION CITY OR TOWN COUNTY STATE BALTO. MD	
24 FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD. BALTO, MD 21215				25a DATE REC'D. BY REGISTRAR JAN 28 1987		25b REGISTRAR'S SIGNATURE Julia Dindon-Rodgers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give the completed pages, Pages 1 and 2, should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send it to the funeral home. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 00371	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thelma Blanche Coleman						2a. DATE OF DEATH MONTH DAY YEAR January 5, 1987			2b. HOUR 8:03AM		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 3 7 96		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9002 Carlisle Avenue 21236			
14. FATHER'S NAME FIRST MIDDLE LAST Jacob Riley Crummett				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Alice Reynolds							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 214-74-4911		17. INFORMANT ADDRESS Mrs. Robert Hart 9002 Carlisle Avenue Baltimore, MD. 21236					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. Heart Failure Hypertension										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from June 19 86 to Jan 5 19 87, that I (we) last saw the deceased alive on Jan 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Howard Bond M.D.					DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1/5/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard Bond M.D.					22e. ADDRESS 9000 Franklin Square Drive 21237						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/7/87		23c. NAME OF CEMETERY OR CREMATORY Rhoadesville Baptist Church Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Locust Grove Orange Virginia				
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc. ADDRESS 8728 Liberty Road Randallstown, MD. 21133						25a. DATE REC'D. BY REGISTRAR JAN 8 1987		25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall			

BP

11/11/11

Dear Sir,
I have the pleasure to acknowledge the receipt of your letter of the 10th inst. in relation to the above matter.
The same has been forwarded to the proper authorities for their consideration.
Very respectfully,
Yours truly,
[Signature]

Enclosed for you are the following documents:
1. A copy of the report of the committee on the subject of the proposed amendment to the constitution.
2. A copy of the report of the committee on the subject of the proposed amendment to the constitution.
3. A copy of the report of the committee on the subject of the proposed amendment to the constitution.

I am, Sir, very respectfully,
Yours truly,
[Signature]
1888

040879 JAN 1987

UNKNOWN #87-4

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

00372

1. DECEASED NAME (TYPE OR PRINT)		THOMAS CARL COLLEY		2a. DATE OF DEATH		KNOWN ESTI- MATED		MONTH DAY YEAR		2b. HOUR	
THOMAS CARL COLLEY				1		4		1987		M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR	
Male	White	11 27 1968	18 YRS.			1		4		1987	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				MD.	
Pennsylvania		U.S.A.				Baltimore County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Chase		Eastern Blvd. & Greenbank Rd.		Student		Art College					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Pennsylvania		Cumberland		Hopewell Twp.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Box 167D, R.D.1, Shippensburg, Pa. 17257			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Thomas		Ann K. Finkbeiner		No		172-56-4755		Dr. Thomas Colley (father)		Box 167D R.D. 1, Shippensburg, Pa. 17257	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Multiple blunt & thermal injuries with smoke inhalation											
8001											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost											
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
		1:30 P.M. 1-4-1987		Occupant of train/train collision.							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
		railroad tracks		Eastern Blvd. & Chase		Baltimore		MD			
22a. I certify that I took charge of the remains described above, held on death resulted from											
Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE		TITLE (SPECIFY)						DATE SIGNED			
Charles P. Kokes, M.D.		M.D. Assistant MEDICAL EXAMINER						1-5-87			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
Charles P. Kokes, M.D.		111 Penn St., Balto., MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		STATE	
Cremation		Jan. 9, 1987		Smithsburg Crematory		Smithsburg, Washington, Md.					
24. FUNERAL DIRECTOR		ADDRESS									
Elaine Funeral Home		Reisterstown, Md. 21136									

FOR Fogelsanger Funeral Home, Shippensburg, Pa. 17257

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR 72 HOURS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1, 2, AND 3 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP

JAN 14 1987
(V) (A) (S) (M) (5)

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Robert		FIRST Collins		MIDDLE Sr		2a. DATE OF DEATH MONTH DAY YEAR 1 14 87		2b. HOUR 1:45 A	
3. SEX Male		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 6 30 48		6. AGE (IN YEARS LAST BIRTHDAY) 38 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pittsville, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Kopper		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE 2013 Longwood St. 21216			
14. FATHER'S NAME FIRST MIDDLE LAST Thomas E. Collins Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Dale					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				16b. SOCIAL SECURITY NO. 214-48-7962		17. INFORMANT ADDRESS Agnes Rose Collins 2013 Longwood St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY AND RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMATOSIS OF ABDOMEN WITH METASTASIS DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA OF THE COLON								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE DR. F. MALEK / BY EDUARDO P. LAYUG						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-14-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. FREIDON MALEK / BY EDUARDO P. LAYUG						22e. ADDRESS ST. JOSEPH HOSPITAL 7620 YORK RD. BALT. MD. 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/17/87		23c. NAME OF CEMETERY OR CREMATORY King Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Leroy O. Dyett 4600 Liberty Heights						25a. DATE REC'D. BY REGISTRAR JAN 18 1987			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the completed page 3 and 4 from the certificate and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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042373 JAN 28 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 00314 REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTHS DAYS HOURS MIN.	
FRANK		January 21, 1987		5:27 am	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. BALTIMORE CITY OR COUNTY OF DEATH	
Male	White	MONTH DAY YEAR	70 YRS	Baltimore County MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Washington	U.S.A.		Baltimore County		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Towson	Greater Baltimore Medical Center		Advertising Exec.		Meat Packing
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Maryland	Baltimore	Towson	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	2 Alabama Ct. 21204	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		
Frank	Leslie	Conners	Yes		
16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
WWII		R.F. Conners 2 Alabama Ct. 21204			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Carcinomatosis					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
(b) Bladder carcinoma					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 11a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
April 1985		Carcinoma of bladder		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 85 to 1/21 19 87, that (I) (we) last saw the deceased alive on 1/20 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE				22c. DATE SIGNED	
R. Breiteneker				1/21/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
Rudiger Breiteneker, M.D.				6701 N. Charles St. Balto MD 21204	
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		1-22-87		Greenmount	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS		JAN 28 1987		Jia Tiedeman	
Mitchell-Wiedefeld Home 6500 York Road 21212					

100-100000

RECEIVED

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]

RE: [Illegible]

On [Illegible] [Illegible] [Illegible]

It is requested that you [Illegible] [Illegible]

Very truly yours,
[Illegible Signature]



cc: [Illegible]

Enclosure

040290 JAN 1987

UNKNOWN #87-9

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

00375

1. DECEASED NAME (TYPE OR PRINT)		FIRST Laura MIDDLE Deberaradino LAST Corti		2a. DATE KNOWN OF DEATH		MONTH <input type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/>		2b. HOUR	
LAURI		DEBERARDINO		1 4 19 87				M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD		7d. HOUR	
Female	White	Aug. 6, 1964	22 YRS.			1 5 19 87		4:05 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
Texas		U.S.A.				Baltimore County			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Chase		Eastern Blvd. & Greenbank Rd.		Tax Assessor		City of N.Y.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
New York				New York		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		142 E. 33rd St. 10016-9999	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		No		451-43-8373		N.Y., N.Y.	
Marco		Deberaradino						Jesse Corti 142 E 33rd St. 10016	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
IMMEDIATE CAUSE (a) <u>Compression asphyxia with multiple injuries</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		1:30 P.M. 1-4- 19 87		Occupant of train/train collision.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY	
		railroad tracks		Eastern Blvd. & Chase		Baltimore		MD	
22a. I certify that I took charge of the remains described above, held on death resulted from		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion							
Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED					
Charles P. Kokes, M.D.		M.D. Assistant		1-5-87					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS							
Charles P. Kokes, M.D.		111 Penn St., Balto., MD		21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN	
Burial		1-8-87		Geo. Wash. Mem. Pk.		Paramus		Bergen	
								New York	
24. FUNERAL DIRECTOR		25a. DATE RECEIVED BY READER		25b. DATE RECEIVED BY READER					
Mitchell-Wiedefeld Home		6500 York Road		21212		JAN 8 1987			

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A MEDICAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove coroner papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for filing and cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows a change or a traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR Film #G627, Item #22d, 5/8/87, sjb		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		87 00319	
1. DECEASED NAME (TYPE OR PRINT) Evelyn Virginia Robey Cottrill		2a. DATE OF DEATH MONTH DAY YEAR January 11, 1987		2b. HOUR 10:10p M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 1, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD	
10. CITY OR TOWN OF DEATH Rossville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary-Lynch		12b. KIND OF BUSINESS OR INDUSTRY Pt. Garage
13a. STATE Maryland		13b. COUNTY Balto.	13c. CITY OR TOWN Essex	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2 Plateau Road 21221
14. FATHER'S NAME FIRST MIDDLE LAST Sulbert Robey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST - Georgia Pearl Padgett			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215- 09-9861		17. INFORMANT ADDRESS Bonnie Moore 313 Patomac Ave. 21237	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Gastrointestinal Bleeding</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Gastritis Liver Failure</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (X) (this hospital) attended the deceased from December 23, 1986, to January 11, 1987, that (X) (we) last saw the deceased alive on January 11, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (do) (do not) view the body after death.					
22b. SIGNATURE Luisa Massari				22c. DATE SIGNED 1-11-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Luisa Massari, MD				22e. ADDRESS 9000 Franklin Square Dr., 21237	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-15-87		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		23e. DATE REC'D. BY REGISTRAR JAN 20			
24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk		25. REGISTRAR'S SIGNATURE [Signature]			

OUTLINE

RESEARCH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove death certificates from the envelope and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR Margaret R. Crespo					7 00311 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Margaret R. Crespo					2a. DATE OF DEATH MONTH DAY YEAR 1 9 87			2b. HOUR 1420 M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 9, 1888		6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD				
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland					13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Humberto Crespo					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 129-30-4689		17. INFORMANT ADDRESS Gustav J. Crespo Same as #13.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE Cardiorespiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ASHD, CHF, Diverticulosis										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Hafeez A Syed MD					DEGREE		22c. DATE SIGNED 1/9/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAFAEEZ A SYED MD					22e. ADDRESS BALTIMORE COUNTY GEN Hosp.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Jan. 12, 1987		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.					ADDRESS 1050 York Road Towson, Md. 21204		25a. DATE REC'D. BY REGISTRAR JAN 12 1987			
					25b. REGISTRAR'S SIGNATURE Julia Division					

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AMSTERDAM

042598 FEB

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 00373

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
MARIA		McEvoy		CROMWELL		1/29/87 12:21 AM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
Female	White	July 22, 1902		84 YRS.			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MD	USA			Baltimore County MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Towson	Greater Baltimore Medical Center			Homemaker		Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. STREET ADDRESS / ZIP CODE			
MD		Balto.		2007 W. Joppa Rd., 21204			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Patrick J. McEvoy		Annie Gallagher					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		216 46 2520		P. McEvoy Cromwell, Towson, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>acute Myocardial infarction</u>						1 hour	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic Heart Disease</u>						years	
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>7/10/1955</u> to <u>1/28/87</u> , that (I) (we) saw the deceased alive on <u>1/28/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>William F. Fritz</u> DEGREE <u>MD</u>				22c. DATE SIGNED <u>1/29/87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. William F. Fritz, MD</u>				22e. ADDRESS <u>2 W. University Pkwy., Balto., MD</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>1/31/87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Balto., MD</u>	
24. FUNERAL DIRECTOR NAME <u>Henry W. Jenkins & Sons Co.</u>				25a. DATE REC'D. BY REGISTRAR <u>JAN 29 1987</u>		25b. REGISTRAR'S SIGNATURE <u>John Anderson-Randall</u>	
4905 York Road Balto., MD 21212							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the deceased's file. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

No. 10 10000 P. No. 10000 P. No. 10000 P. No. 10000 P. No. 10000 P.
 Patrick J. McVoy
 Town of
 Baltimore, Md.
 July 22, 1900
 Hon. W. J. Johnson
 Baltimore, Md.



JUL 22 1900
 BALTIMORE, MD.

Mr. William F. Fries, Baltimore, Md.
 New Cathedral
 Baltimore, Md.
 July 22, 1900
 Hon. W. J. Johnson & Son Co.
 Baltimore, Md.

041439 JAN 21 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 00379
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUTH E. (Dorsey) CROWNER			2a DATE OF DEATH MONTH DAY YEAR 1 15 87			2b HOUR 1:15 M	
3 SEX Female		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR 9 5 13		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 73	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Old Court N.H.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) -	
13a STATE Maryland		13b COUNTY BALTO.		13c CITY OR TOWN Baltimore		13d SIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Dennis		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Davis		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No ---			
16b SOCIAL SECURITY NO. ---		17 INFORMANT ADDRESS Dennis Johnson Jr. 8525 Winnans Rd.					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Dishite</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Dishite</u>							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 19 57 to 1/15 87, that (I) (we) lost saw the deceased alive on 1/10 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <u>Morton J. Ellin, M.D.</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 1/15/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Morton J. Ellin, M.D.		22e ADDRESS 5310 Old Court Road Randallstown, MD 21133					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/18/87		23c NAME OF CEMETERY OR CREMATORY St. Thomas Ch. Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Randallstown Md.	
24 FUNERAL DIRECTOR NAME W.C. March F.H. 4300 Wabash Ave.				25a. DATE REC'D. BY REGISTRAR JAN 20 1987			
				25b REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place in the box on page 3 the name of the funeral home, the name of the funeral director, and the name of the funeral home. The State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, in other traumatic event, the medical examiner must be notified.

DATE

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3



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Calvin Charles CRUSSE			2a. DATE OF DEATH MONTH DAY YEAR January 30, 1987			2b. HOUR 2:00 a.m.					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 9 1924		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN Rosedale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1800 Weyburn Road 21237		
14. FATHER'S NAME FIRST MIDDLE LAST Charles Crusse				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Collins							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW1				16b. SOCIAL SECURITY NO. 216-18-6034		17. INFORMANT ADDRESS Irene Lader 1800 Weyburn Road 21237					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER).		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>January 27</u> , 19 <u>87</u> , to <u>January 30</u> , 19 <u>87</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>January 30</u> , 19 <u>87</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (we) view the body after death.							
22b. SIGNATURE <u>Sarah L. Owens</u>				DEGREE M.D.		22c. DATE SIGNED 1-30-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sarah L. Owens, M.D.				22e. ADDRESS 9000 Franklin Square Dr., 21237			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/2/87		23c. NAME OF CEMETERY OR CREMATORY St. Andrews Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Dundalk Balto. Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Connelly Funeral Home 300 Mace Ave. 21221				25a. DATE REC'D. BY REGISTRAR FEB 4 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Pendall</u>	

1

042870 FEB

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00381
REG. NO.

1- FOR STATE REGISTRAR		DECEASED NAME FIRST MIDDLE LAST THELMA VIRGINIA COE										2a. DATE KNOWN OF ESTI- DEATH MATED 1/31/1987		2b. HOUR 1:30 PM	
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 8 19 1903	6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	9. DATE PRONOUNCED DEAD 1/31/1987	10. MONTH DAY YEAR	11. HOUR	12. DATE PRONOUNCED DEAD 1/31/1987	13. MONTH DAY YEAR	14. HOUR	15. BALTIMORE CITY OR COUNTY OF DEATH BALTO COUNTY MD			
16. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. D. C.		17. CITIZEN OF WHAT COUNTRY? U. S. A.		18. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		19. BALTIMORE CITY OR COUNTY OF DEATH BALTO COUNTY MD		20. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRACTICAL NURSE		21. KIND OF BUSINESS OR INDUSTRY CHILDRENS HOME		22. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) BALTIMORE 62 1/2 WINTERS LANE [CATONSVILLE]			
23. STATE MARYLAND		24. CITY OR TOWN BALTIMORE		25. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		26. STREET ADDRESS 62 1/2 Winters Lane Baltimore		27. CITY OR TOWN BALTIMORE		28. STATE MARYLAND		29. FATHER'S NAME FIRST MIDDLE LAST JOHN HATCHER			
30. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLOSSIE TOMS		31. SOCIAL SECURITY NO. 213-20-1863		32. INFORMANT Mr. Edward Coe		33. ADDRESS Baltimore, Maryland 21228		34. DATE 1/31/1987		35. SIGNATURE F. P. Williamson		36. MEDICAL EXAMINER M.D. ADDRESS 5550 BANTON AVE K21228			
37. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		38. SOCIAL SECURITY NO. 213-20-1863		39. INFORMANT Mr. Edward Coe		40. ADDRESS Baltimore, Maryland 21228		41. DATE 1/31/1987		42. SIGNATURE F. P. Williamson		43. MEDICAL EXAMINER M.D. ADDRESS 5550 BANTON AVE K21228			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE F. P. Williamson				TITLE (SPECIFY) M.D.				MEDICAL EXAMINER DATE 1/31/1987				SIGNATURE F. P. Williamson			
EXAMINER'S NAME (TYPE OR PRINT) F. P. Williamson				ADDRESS 5550 BANTON AVE K21228				DATE 1/31/1987				SIGNATURE F. P. Williamson			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 2/06/1987				23c. NAME OF CEMETERY OR CREMATORY WESTERN STAR CEMETERY				23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR NAME NUNER & SONS FUNERAL HOME, INC. 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216				25a. DATE REC'D. BY REGISTRAR FEB 3 1987				25b. REGISTRAR'S SIGNATURE John Frederick							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Their place relative to the coroner's papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, a serious injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 00382				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Paul J. Culotta				2a. DATE OF DEATH MONTH DAY YEAR January 9 1987				2b. HOUR 10:00 P
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR September 1, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 86		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore county MD.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician, General Elevator		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY Anne Arundel	13c. CITY OR TOWN Edgewater	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2704 Cassia Drive, 21037		
FATHER'S NAME FIRST MIDDLE LAST Vincent P. Culotta		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Liberto						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES No		16b. SOCIAL SECURITY NO. 577-05-8793		17. INFORMANT ADDRESS Angela Strovel, same as #13e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) UTI Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Severe CVA & B hemiparesis, PVD								
19a. DATE OF OPERATION 1/4/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Embolectomy		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1/9/87 to 1/9/87 that (I) (we) lost 1/9/87 above. (I) (we) did not view the body after death.								
22b. SIGNATURE Alan M. Shorofsky MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/11/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN M SHOROFSKY		22e. ADDRESS 660 KENILWORTH AVE 21204						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-13-87		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Timonium, Maryland		
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.		ADDRESS 1050 York Rd. Towson, Md. 21204		25a. DATE REC'D. BY REGISTRAR JAN 14 1987		25b. REGISTRAR'S SIGNATURE Julia T. Ruck		

BP

transformation

map

AVD - (B) - AVD

transformation

1/12

AVD - (B) - AVD

042256 JAN 29 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

87 00383

1. DECEASED NAME (TYPE OR PRINT)										2. DATE OF DEATH KNOWN OF ESTI- MATED		3. MONTH DAY YEAR		4. HOUR					
Charles J Czynewski Jr.										1-23		19		87					
5. SEX		6. RACE		7. DATE OF BIRTH MONTH DAY YEAR		8. AGE (IN YEARS LAST BIRTHDAY)		9. IF UNDER 1 YR. MONTHS DAYS		10. IF UNDER 24 HRS. HOURS MIN.		11. DATE Pronounced DEAD		12. HOUR					
Male		White		5 4 1951		36 YRS.						1-23		19 87 6:55 p.m.					
13. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				14. CITIZEN OF WHAT COUNTRY?				15. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				16. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland				U.S.A.								Baltimore County, MD							
17. CITY OR TOWN OF DEATH				18. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				19. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				20. KIND OF BUSINESS OR INDUSTRY							
Rossville				Franklin Square Hospital				Disability											
21. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										22. STATE		23. COUNTY		24. CITY OR TOWN		25. INSIDE CITY LIMITS?			
										Maryland		Baltimore		Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
26. FATHER'S NAME FIRST MIDDLE LAST										27. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Charles Czynewski										Lydia Vanoli									
28. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				29. SOCIAL SECURITY NO.				30. INFORMANT ADDRESS											
NO				217-58-8826				Lydia Czynewski Same as 13e											
31. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Seizure Disorder</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
32. DATE OF OPERATION				33. CONDITION FOR WHICH OPERATION WAS PERFORMED?								34. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
35. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				36. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				37. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
38. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				39. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				40. LOCATION STREET CITY OR TOWN COUNTY STATE											
41. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
42. ACTUAL SIGNATURE				43. TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				44. DATE SIGNED				1-24-87							
45. EXAMINER'S NAME (TYPE OR PRINT)				46. ADDRESS				111 Penn St., Balto., Md. 21201											
47. BURIAL, CREMATION, REMOVAL (SPECIFY)				48. DATE				49. NAME OF CEMETERY OR CREMATORY				50. LOCATION CITY OR TOWN COUNTY STATE							
Cremation				1-26-87				Westview Cemetery				Baltimore Maryland							
51. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave Dundalk, Md 21222																			
52. DATE REC'D. BY REGISTRAR 53. REGISTRAR'S SIGNATURE JAN 28 1987																			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TENANT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

8000 55

204-01 4 1 000 0



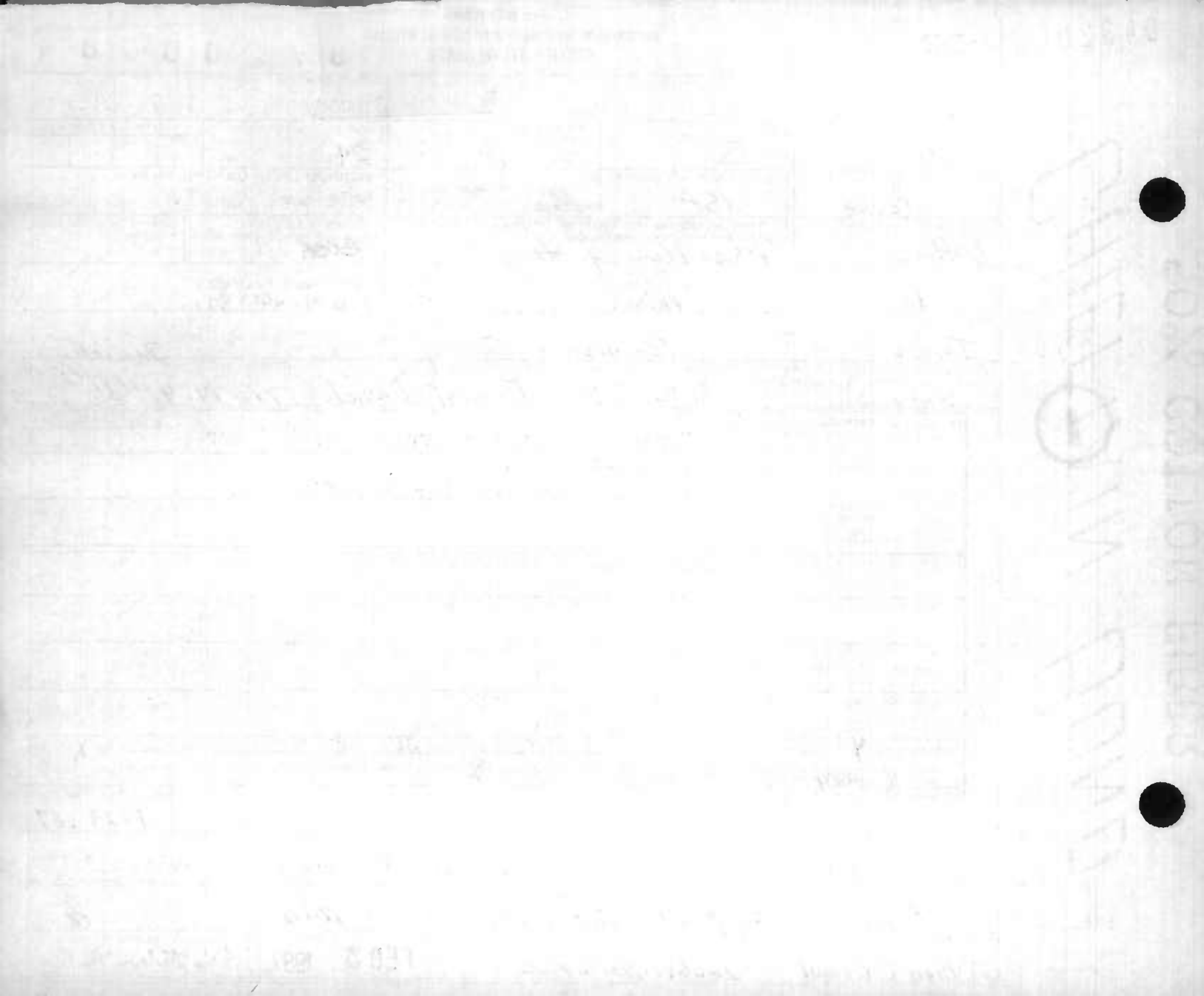
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complies with the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove and complete pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be called to make an autopsy.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 00384	
1. DECEASED NAME (TYPE OR PRINT) James L DANIELS			2a. DATE OF DEATH MONTH DAY YEAR January 29 1987		2b. HOUR 1:53 p.m.
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 2 18 62	6. AGE (IN YEARS LAST BIRTHDAY) 24 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Sq. Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Pa.	13b. COUNTY Phila.	13c. CITY OR TOWN Phila.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 116 N. 49th St. 99999	
14. FATHER'S NAME (PRINT) James		15. MOTHER'S MAIDEN NAME Sally		ADDRESS Daniels	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown		16b. SOCIAL SECURITY NO. 176-56-2777	17. INFORMANT Ernest Daniels 116 N. 49th St. Phila Pa. 19139		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio- Respiratory Arrest, Right Upper Lobe Pneumonia. DUE TO, OR AS A CONSEQUENCE OF (b) Possible Acquired Immune Deficiency. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that X (this hospital) attended the deceased from January 7, 19 87, to January 29, 19 87, that X (we) lost above, X (we) did not view the body after death.					
22b. SIGNATURE R. Fontenot		DEGREE MD.		22c. DATE SIGNED 1-29-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. Fontenot MD.		22e. ADDRESS 9000 Franklin Square Dr., Balt. 21237			
23a. (BURIAL, CREMATION, REMOVAL) (SPECIFY) Burial	23b. DATE 2/7/87	23c. NAME OF CEMETERY OR CREMATORY Mt. Peace		23d. LOCATION (CITY OR TOWN) Phila	STATE Pa.
24. FUNERAL DIRECTOR NAME William C. Brown		ADDRESS 1206 W. North Ave		25a. DATE REC'D. BY REGISTRAR FEB 3 1987	
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					



040736 JAN 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 00385

1. DECEASED NAME (TYPE OR PRINT) Harry John DAVIS			2a. DATE OF DEATH MONTH DAY YEAR January 10, 1987		2b. HOUR MIN. 2:05p						
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9/18/19		6. AGE (IN YEARS LAST BIRTHDAY) 67		IF UNDER 1 YEAR MONTHS DAYS 7 0		IF UNDER 24 HRS HOURS MIN. 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Rossville 21237		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN CITY, GIVE STREET ADDRESS) Franklin Sq. Hospital						12a. USUAL OCCUPATION (TYPE WORK FOR EMPLOYER) Heavy Equipment Operator		12b. KIND OF BUSINESS OR INDUSTRY Construction	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. CITY OR TOWN Baltimore		13c. CITY OR TOWN Middle River		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1213 Tupelo Place 21220			
14. FATHER'S NAME FIRST MIDDLE LAST George W. Davis						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Shipley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS Isabelle Davis, Wife Same					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Respiratory Arrest**Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Mucous Plug**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Chronic Obstructive Lung Disease**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from December 28, 1986 to January 10, 1987 , that (I) (we) last saw the deceased alive on January 10, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Kirk R. Steptoe</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-10-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kirk R. Steptoe MD.				22e. ADDRESS 9000 Franklin Square Drive			

23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 1/13/87		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.	
24. FUNERAL DIRECTOR NAME Brudzinski Funeral Home PA 1407 Old Eastern Ave				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>John G. ...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return all four papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If death is marked as item 18, a copy of any injury, or other traumatic event, the medical examiner must be notified at once.

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• *BY THE EDITOR*

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041585 JAN 22 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 1000. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Item # 253823D, Film G 623,		STATE OF MARYLAND	
1- FOR STATE REGISTRAR 1/27/87 I.J.		DEPARTMENT OF HEALTH AND MENTAL HYGIENE	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 00380	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST KENDALL T. DEAN		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 18 19 87 2b. HOUR M 8:10 AM	
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 3/31/87	6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 9 IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 357 N. Belmont Ave.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) -----		12b. KIND OF BUSINESS OR INDUSTRY -----	
13a. STATE Maryland		13b. COUNTY Balto.	
13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 357 Beaumont Ave. 21228	
14. FATHER'S NAME FIRST MIDDLE LAST Emanuel Dean		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Catherine Redd	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A	
17. INFORMANT ADDRESS Mary C. Dean 357 Beaumont Ave 21228			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden Infant Death Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Charles P. Kokes</i>		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.		DATE SIGNED 1-19-87	
ADDRESS 111 Penn St., Balto., MD 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/21/87	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.	23d. LOCATION CITY/TOWN Baltimore COUNTY STATE Md.
24. FUNERAL DIRECTOR W.E. March F.H. 4300 Wabash Ave.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 20 1987 <i>Julia Davidson-Landack</i>	

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042234 JAN 29 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 00381
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Marie DeChriste			2a DATE OF DEATH MONTH DAY YEAR January 22 1987		2b HOUR M AM
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR September 5 1917		6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10 CITY OR TOWN OF DEATH Dundalk	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7919 Gray Haven Road 21222		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress	12b KIND OF BUSINESS OR INDUSTRY Howard Uniform	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md			13b COUNTY Baltimore	13c CITY OR TOWN Dundalk	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
FATHER'S NAME FIRST MIDDLE LAST Maxamillian Majerowicz			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marianne Brocki		
14a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		14b SOCIAL SECURITY NO. 213-03-6648		17 INFORMANT ADDRESS Dundalk, MD 21222 Mrs Verlie Vanko 7919 Gray Haven Rd.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ovarian Cancer DUE TO, OR AS A CONSEQUENCE OF (c) N/A APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: N/A					
19a DATE OF OPERATION N/A		19b CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR N/A		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) N/A	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT AT WORK <input checked="" type="checkbox"/> N/A		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f LOCATION STREET CITY OR TOWN COUNTY STATE N/A	
22a I certify that (I) (this hospital) attended the deceased from Sept. 21 , 19 83 , to Dec. 29 , 19 86 , that (I) (we) lost saw the deceased alive on Dec. 29 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Dr. Neil Rosenshein				22c DATE SIGNED 1/23/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Neil Rosenshein		22e ADDRESS 515 N. Broadway			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 1/26/87	23c NAME OF CEMETERY OR CREMATORY St. Stanislaus	23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		
24 FUNERAL DIRECTOR NAME 7922 Wise Ave. Dundalk, MD 21222 Duda-Ruck Funeral Home of Dundalk, Inc.			25a DATE REC'D BY REGISTRAR JAN 28 1987		

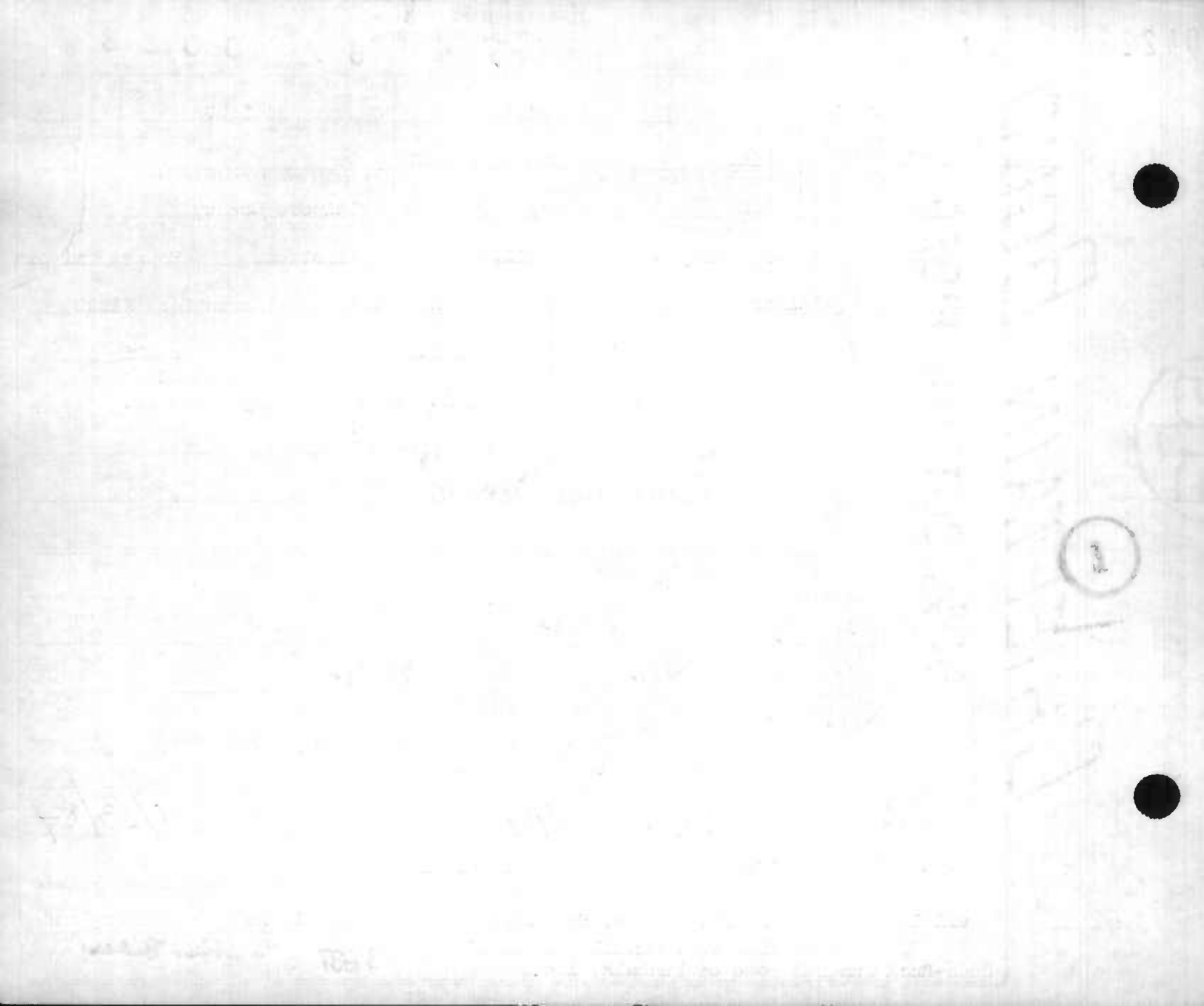
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. When the funeral home has been notified of the death, the funeral home should be notified of the death with the State Dept. of Health and Mental Hygiene. Please note: If the death is a result of an injury, or other traumatic event, the medical examiner should be notified of the death.

IMPORTANT: If item 21 is marked as item 18, item 18 should be filled in.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 checked, only injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 0 0 3 8 8
REG. NO.

1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT) Mary E. Deitz		2b. DATE OF DEATH January 14 1987		2c. HOUR 356 PM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH March 31 1890		6. AGE (IN YEARS LAST BIRTHDAY) 96	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County	
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Summitt Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Woodstock		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME (TYPE OR PRINT) Edward Knox Poe		15. MOTHER'S MAIDEN NAME Nancy Vaught		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212-26-4854	
17a. ADDRESS 9201 Wrights Mill Road		17b. ADDRESS 9201 Wrights Mill Road		17c. ADDRESS 9201 Wrights Mill Road		17d. ADDRESS 9201 Wrights Mill Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) HSCVD DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12 Dec 1986</u> to <u>14 Jan 1987</u> , that (I) (we) lost saw the deceased alive on <u>13 Jan 1987</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE James E Rowe MD		DEGREE MD		22c. DATE SIGNED 1/15/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JE ROWE MD		22e. ADDRESS Summitt Nursing Home					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/17/87		23c. NAME OF CEMETERY OR CREMATORY Mount Olive Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown Baltimore MD.	
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc.		24b. ADDRESS 8728 Liberty Road Randallstown, MD. 21133		25a. DATE REC'D. BY REGISTRAR JAN 16 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall	

041749 JAN 27 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

00389

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Joseph J. Delaney</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>1 16 87</i>		2b. HOUR <i>2:45</i> A M
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>4 3 04</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>82</i> YRS	7. UNDER 1 YEAR MONTHS DAYS <i>82</i>
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>PA. U.S.A.</i>	9. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.	
12. CITY OR TOWN OF DEATH <i>Randallstown</i>	13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Old Court Nursing Center</i>		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>CARPENTER/ESTIMATOR</i>		15. KIND OF BUSINESS OR INDUSTRY
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE <i>MD.</i> 16b. COUNTY <i>BALTO.</i>		17. CITY OR TOWN <i>BALTO.</i>	18. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	19. STREET ADDRESS / ZIP CODE <i>1600 W. MOUNT ROYAL AVE.</i>	
20. FATHER'S NAME FIRST MIDDLE LAST <i>JOHN DEANEY</i>		21. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MARY BROGAN</i>			
22. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>		23. SOCIAL SECURITY NO. <i>213-09-8493</i>		24. INFORMANT ADDRESS <i>DOLORES MORAN 622 E. 31ST ST</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardio pulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

ASCVD

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH*10 minutes**10 years*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19 80</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>7-4</i> 19 <i>80</i> , to <i>1-16</i> 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>1-12</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>MB Pearlman</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>1-17-87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MB PEARLMAN</i>		22e. ADDRESS <i>5400 OLD COURT RD</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>CREMATION</i>	23b. DATE <i>1-17-87</i>	23c. NAME OF CEMETERY OR CREMATORY <i>WESTVIEW MEM PK BALTO</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTO MD</i>
24. FUNERAL DIRECTOR NAME ADDRESS <i>EDWARD J. WEBER F.H. 5311 EDMONDSON</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 23 1987</i>	
		25b. REGISTRAR'S SIGNATURE <i>Julia Anderson-Randall</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the officiating clergyman and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the permit to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. Page 4 may be retained by the funeral director. IMPORTANT: If item 21 is marked or item 18 above is marked, item 18 above is marked, item 18 above is marked, item 18 above is marked.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARIA R. de LARA					2a. DATE OF DEATH MONTH DAY YEAR JANUARY 11, 1987			2b. HOUR 7:55 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 28, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Phillipines		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Technologist		12b. KIND OF BUSINESS OR INDUSTRY Medical	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY Baltimore 13c CITY OR TOWN Towson					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1012 Marleigh Circle 21204		
14. FATHER'S NAME FIRST MIDDLE LAST Maximiniano Reyes				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Zoila Tolentino					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 212-78-2182		17. INFORMANT ADDRESS Phoenix, Md. Nelson R. de Lara-26 Glen Alpine Rd. 21131			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest, M.I.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe, Generalized ABCD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Head-on Motor Vehicle</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 mins</u> <u>> 20 yrs</u> <u>> 20 yrs</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>1-7-87</u> 19 <u>87</u> to <u>1-11-87</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>1-11-87</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John J. Messina M.D.</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1-11-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John J. Messina M.D.					22e. ADDRESS 7401 Cedar Drive Towson, MD. 21204				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE 1-13-87		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Maus.		23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville, Balto., Md.			
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204					25a. DATE REC'D. BY REGISTRAR JAN 14 1987		25b. REGISTRAR'S SIGNATURE Julia Terison-Randall		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

Item: 16b 1/27/87		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		87 00391	
FOR STATE REGISTRAR		G-623 FH cm		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR	
Margaret E. DePasquale				1 13 87	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	
Female		White		11-15-1916	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Balto. Md.		U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
TOWSON		Greater Baltimore Medical Center		Exon	
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS / ZIP CODE	
MD.		Balto.		7 Mopec Circle Apt. C -21236	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Marino		Marguerite Ryan		16b. SOCIAL SECURITY NO. 214-03-4947	
17. INFORMANT ADDRESS		17. INFORMANT ADDRESS		21236	
Joseph M. DePasquale -7 Mopec Circle Apt. C					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Necrotizing bronchopneumonia					
DUE TO, OR AS A CONSEQUENCE OF					
(b) Metastatic carcinoma of lung					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/26, 1986, to 1/13 1987, that (I) (we) last saw the deceased alive on 1/13/1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Leslie L. Walters, M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		1/13/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Leslie L. Walters, M.D.		6701 North Charles Street 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		1-16-87		Gardens of Faith Cem. Balto. Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR	
John C. Miller, Inc.-6415 Belair Rd.-21206				25b. REGISTRAR'S SIGNATURE	
				JAN 14 1987	

④ 11/11/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please replace carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 00392
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph Michael DIBLASI			2a. DATE OF DEATH MONTH DAY YEAR January 19, 1987		2b. HOUR 5:53 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 7, 1951		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Rossville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pres. Druid Hill		12b. KIND OF BUSINESS OR INDUSTRY Fed. S. & L.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Baltimore	13c. CITY OR TOWN Parkville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS, ZIP CODE 8711 Fowler Avenue 21234
14. FATHER'S NAME FIRST MIDDLE LAST Frank DiBlasi		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary C. Rotunda			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 214-26-4127		17. INFORMANT ADDRESS Mrs. Keiko DiBlasi Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from January 19, 1987 to January 19, 1987 , that (I) (we) last saw the deceased alive on January 19, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>John Butler M.D.</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Butler M.D.		22e. ADDRESS 9000 Franklin Square Drive 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 23, 1987		23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.		23e. DATE REC'D. BY REGISTRAR			
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck Inc. Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR JAN 21 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Tindin-Randall</i>	

BP. _____

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 00393

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE (aka) LAST JOSEPHINE MARY DOBRZYKOWSKI		2a. DATE OF DEATH MONTH DAY YEAR January 15, 1987		2b. HOUR 12:40 PM	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR March 17, 1904	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Rosedale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Can Mfg.			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST James Nowak		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Cywinski			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-10-7674		17. INFORMANT ADDRESS Cheryl Dobrzykowski-2109 Rosalie Ave. 21221	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Underlying event</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>large and small bowel infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>admission</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>admission</u>					
19a. DATE OF OPERATION 7/28/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED bowel infarction		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (X) (this hospital) attended the deceased from July 23, 1986, to January 15, 1987, that (X) (we) last saw the deceased alive on January 15, 1987, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Alfred L. L...</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/15/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. SANT ANTONIO		22e. ADDRESS 901 EASTERN BLVD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/19/87		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland					
24. FUNERAL DIRECTOR NAME George A. Weber & Sons Inc. 705 S. Ann ST. 21231		25a. DATE REC'D. BY REGISTRAR JAN 16 1987		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return completed pages 1 and 2 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 38 about any injury or other traumatic event, the medical examiner's services will be called to aid.

(aka name)

I

62

100

March 17, 1962

x

Supervisor

2101 in a box, 2101-2102

2101 in a box, 2101-2102

x

1/12/67

1/12/67

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Margaret Ryan Donahue			2a. DATE OF DEATH MONTH DAY YEAR Jan. 13 1987			2b. HOUR 8A M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 31 1897		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 89		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 8A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Lutherville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8213 White Manor Drive, 21093				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Registered Nurse		12b. KIND OF BUSINESS OR INDUSTRY Nursing	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Lutherville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8213 White Manor Drive, 21093	
14. FATHER'S NAME FIRST MIDDLE LAST Daniel Aloysius Ryan					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret McNally				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -			17. INFORMANT ADDRESS 21093 Margaret D. Flanigan, 8213 White Manor Dr			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) astrocytoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/22 , 19 86 , to 1/13 , 19 87 , that (I) (we) last saw the deceased alive on 1/9 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE Carla S. Alexander, MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CARLA S. ALEXANDER				22e. ADDRESS 2300 Dulaney Valley Rd.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/17/87		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Martin D. Lawson, 10 W. Padonia Rd. 21093				25a. DATE REC'D. BY REGISTRAR JAN 16 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodgers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return it to the Bureau of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 22 is marked, the medical examiner must be notified.

[Faint, mostly illegible text and markings covering the page body]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

040867 JAN 15 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				87 00395 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Deeman, ELLA DORMAN				2a. DATE OF DEATH MONTH DAY YEAR 01 6 87				2b. HOUR 11 PM			
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR MAR. 31, 1899		6 AGE (IN YEARS (LAST BIRTHDAY)) 87 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GEN. HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME			
13a. STATE MARYLAND		13b. COUNTY BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6TH FL 2500 W. BELVEDERE AVE. 21215					
14. FATHER'S NAME FIRST MIDDLE LAST HERMAN ABRAMOVITZ		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HANNAH UNKNOWN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-30-3503		17. INFORMANT ADDRESS MRS. RUTH HIGHTOW APT. F 8003 MOLLYE RD. #21208							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 10 <u>CVA @ Hypertension</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>2/2/87</u> 19 <u>86</u> to <u>01/6/87</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>01/6/87</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>01/6/87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M. ENOUR</u>				22e. ADDRESS BCGH - 5401 OLD COURT RD. RANDALLSTOWN, MD							
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE JAN. 8, 1987		23c. NAME OF CEMETERY OR CREMATORY CHEVRA AHAVAS CHESD		23d. LOCATION CITY OR TOWN COUNTY STATE RANDALLSTOWN BALTO. MD					
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR <u>JAN 15 1987</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

2 1/2 COTTON BEEB



2 1/2 COTTON BEEB



040069 JAN 16 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 00390

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELSIE Elizabeth DOSCH			2a. DATE OF DEATH MONTH DAY YEAR 1 3 87		2b. HOUR 7:04A M						
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 21 13		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC-6701 N. CHARLES ST.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY Housework		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. ST. AL. 13b. COUNTY Baltimore 13c. CITY OR TOWN Graceland Pk.				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6742 Bessemer Ave. 21222					
14. FATHER'S NAME FIRST MIDDLE LAST John Henry Stickline				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Lind							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-01-6522		17. INFORMANT ADDRESS William L. Dosch 6742 Bessemer Ave. 21222							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC/RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC ADENOCARCINOMA TO LIVER AND LUNGS</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MIN 6 MONTHS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/9</u> , 19 <u>86</u> , to <u>1/3</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>1/2</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) did not) view the body after death.											
22b. SIGNATURE David Jundel mo						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/4/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID TUNKEI M.D.						22e. ADDRESS GBMC- 6701 N. CHARLES ST.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-06-87		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith			23d. LOCATION CITY OR TOWN COUNTY STATE Overlea Balto Co., Md.			
24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc. ADDRESS 6224 Eastern Ave						25a. DATE REC'D. BY REGISTRAR JAN 6 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon pages 4 and 5 and 6 and 7 and 8 and 9 and 10 and 11 and 12 and 13 and 14 and 15 and 16 and 17 and 18 and 19 and 20 and 21 and 22 and 23 and 24 and 25 and 26 and 27 and 28 and 29 and 30 and 31 and 32 and 33 and 34 and 35 and 36 and 37 and 38 and 39 and 40 and 41 and 42 and 43 and 44 and 45 and 46 and 47 and 48 and 49 and 50 and 51 and 52 and 53 and 54 and 55 and 56 and 57 and 58 and 59 and 60 and 61 and 62 and 63 and 64 and 65 and 66 and 67 and 68 and 69 and 70 and 71 and 72 and 73 and 74 and 75 and 76 and 77 and 78 and 79 and 80 and 81 and 82 and 83 and 84 and 85 and 86 and 87 and 88 and 89 and 90 and 91 and 92 and 93 and 94 and 95 and 96 and 97 and 98 and 99 and 100 and 101 and 102 and 103 and 104 and 105 and 106 and 107 and 108 and 109 and 110 and 111 and 112 and 113 and 114 and 115 and 116 and 117 and 118 and 119 and 120 and 121 and 122 and 123 and 124 and 125 and 126 and 127 and 128 and 129 and 130 and 131 and 132 and 133 and 134 and 135 and 136 and 137 and 138 and 139 and 140 and 141 and 142 and 143 and 144 and 145 and 146 and 147 and 148 and 149 and 150 and 151 and 152 and 153 and 154 and 155 and 156 and 157 and 158 and 159 and 160 and 161 and 162 and 163 and 164 and 165 and 166 and 167 and 168 and 169 and 170 and 171 and 172 and 173 and 174 and 175 and 176 and 177 and 178 and 179 and 180 and 181 and 182 and 183 and 184 and 185 and 186 and 187 and 188 and 189 and 190 and 191 and 192 and 193 and 194 and 195 and 196 and 197 and 198 and 199 and 200 and 201 and 202 and 203 and 204 and 205 and 206 and 207 and 208 and 209 and 210 and 211 and 212 and 213 and 214 and 215 and 216 and 217 and 218 and 219 and 220 and 221 and 222 and 223 and 224 and 225 and 226 and 227 and 228 and 229 and 230 and 231 and 232 and 233 and 234 and 235 and 236 and 237 and 238 and 239 and 240 and 241 and 242 and 243 and 244 and 245 and 246 and 247 and 248 and 249 and 250 and 251 and 252 and 253 and 254 and 255 and 256 and 257 and 258 and 259 and 260 and 261 and 262 and 263 and 264 and 265 and 266 and 267 and 268 and 269 and 270 and 271 and 272 and 273 and 274 and 275 and 276 and 277 and 278 and 279 and 280 and 281 and 282 and 283 and 284 and 285 and 286 and 287 and 288 and 289 and 290 and 291 and 292 and 293 and 294 and 295 and 296 and 297 and 298 and 299 and 300 and 301 and 302 and 303 and 304 and 305 and 306 and 307 and 308 and 309 and 310 and 311 and 312 and 313 and 314 and 315 and 316 and 317 and 318 and 319 and 320 and 321 and 322 and 323 and 324 and 325 and 326 and 327 and 328 and 329 and 330 and 331 and 332 and 333 and 334 and 335 and 336 and 337 and 338 and 339 and 340 and 341 and 342 and 343 and 344 and 345 and 346 and 347 and 348 and 349 and 350 and 351 and 352 and 353 and 354 and 355 and 356 and 357 and 358 and 359 and 360 and 361 and 362 and 363 and 364 and 365 and 366 and 367 and 368 and 369 and 370 and 371 and 372 and 373 and 374 and 375 and 376 and 377 and 378 and 379 and 380 and 381 and 382 and 383 and 384 and 385 and 386 and 387 and 388 and 389 and 390 and 391 and 392 and 393 and 394 and 395 and 396 and 397 and 398 and 399 and 400 and 401 and 402 and 403 and 404 and 405 and 406 and 407 and 408 and 409 and 410 and 411 and 412 and 413 and 414 and 415 and 416 and 417 and 418 and 419 and 420 and 421 and 422 and 423 and 424 and 425 and 426 and 427 and 428 and 429 and 430 and 431 and 432 and 433 and 434 and 435 and 436 and 437 and 438 and 439 and 440 and 441 and 442 and 443 and 444 and 445 and 446 and 447 and 448 and 449 and 450 and 451 and 452 and 453 and 454 and 455 and 456 and 457 and 458 and 459 and 460 and 461 and 462 and 463 and 464 and 465 and 466 and 467 and 468 and 469 and 470 and 471 and 472 and 473 and 474 and 475 and 476 and 477 and 478 and 479 and 480 and 481 and 482 and 483 and 484 and 485 and 486 and 487 and 488 and 489 and 490 and 491 and 492 and 493 and 494 and 495 and 496 and 497 and 498 and 499 and 500 and 501 and 502 and 503 and 504 and 505 and 506 and 507 and 508 and 509 and 510 and 511 and 512 and 513 and 514 and 515 and 516 and 517 and 518 and 519 and 520 and 521 and 522 and 523 and 524 and 525 and 526 and 527 and 528 and 529 and 530 and 531 and 532 and 533 and 534 and 535 and 536 and 537 and 538 and 539 and 540 and 541 and 542 and 543 and 544 and 545 and 546 and 547 and 548 and 549 and 550 and 551 and 552 and 553 and 554 and 555 and 556 and 557 and 558 and 559 and 560 and 561 and 562 and 563 and 564 and 565 and 566 and 567 and 568 and 569 and 570 and 571 and 572 and 573 and 574 and 575 and 576 and 577 and 578 and 579 and 580 and 581 and 582 and 583 and 584 and 585 and 586 and 587 and 588 and 589 and 590 and 591 and 592 and 593 and 594 and 595 and 596 and 597 and 598 and 599 and 600 and 601 and 602 and 603 and 604 and 605 and 606 and 607 and 608 and 609 and 610 and 611 and 612 and 613 and 614 and 615 and 616 and 617 and 618 and 619 and 620 and 621 and 622 and 623 and 624 and 625 and 626 and 627 and 628 and 629 and 630 and 631 and 632 and 633 and 634 and 635 and 636 and 637 and 638 and 639 and 640 and 641 and 642 and 643 and 644 and 645 and 646 and 647 and 648 and 649 and 650 and 651 and 652 and 653 and 654 and 655 and 656 and 657 and 658 and 659 and 660 and 661 and 662 and 663 and 664 and 665 and 666 and 667 and 668 and 669 and 670 and 671 and 672 and 673 and 674 and 675 and 676 and 677 and 678 and 679 and 680 and 681 and 682 and 683 and 684 and 685 and 686 and 687 and 688 and 689 and 690 and 691 and 692 and 693 and 694 and 695 and 696 and 697 and 698 and 699 and 700 and 701 and 702 and 703 and 704 and 705 and 706 and 707 and 708 and 709 and 710 and 711 and 712 and 713 and 714 and 715 and 716 and 717 and 718 and 719 and 720 and 721 and 722 and 723 and 724 and 725 and 726 and 727 and 728 and 729 and 730 and 731 and 732 and 733 and 734 and 735 and 736 and 737 and 738 and 739 and 740 and 741 and 742 and 743 and 744 and 745 and 746 and 747 and 748 and 749 and 750 and 751 and 752 and 753 and 754 and 755 and 756 and 757 and 758 and 759 and 760 and 761 and 762 and 763 and 764 and 765 and 766 and 767 and 768 and 769 and 770 and 771 and 772 and 773 and 774 and 775 and 776 and 777 and 778 and 779 and 780 and 781 and 782 and 783 and 784 and 785 and 786 and 787 and 788 and 789 and 790 and 791 and 792 and 793 and 794 and 795 and 796 and 797 and 798 and 799 and 800 and 801 and 802 and 803 and 804 and 805 and 806 and 807 and 808 and 809 and 810 and 811 and 812 and 813 and 814 and 815 and 816 and 817 and 818 and 819 and 820 and 821 and 822 and 823 and 824 and 825 and 826 and 827 and 828 and 829 and 830 and 831 and 832 and 833 and 834 and 835 and 836 and 837 and 838 and 839 and 840 and 841 and 842 and 843 and 844 and 845 and 846 and 847 and 848 and 849 and 850 and 851 and 852 and 853 and 854 and 855 and 856 and 857 and 858 and 859 and 860 and 861 and 862 and 863 and 864 and 865 and 866 and 867 and 868 and 869 and 870 and 871 and 872 and 873 and 874 and 875 and 876 and 877 and 878 and 879 and 880 and 881 and 882 and 883 and 884 and 885 and 886 and 887 and 888 and 889 and 890 and 891 and 892 and 893 and 894 and 895 and 896 and 897 and 898 and 899 and 900 and 901 and 902 and 903 and 904 and 905 and 906 and 907 and 908 and 909 and 910 and 911 and 912 and 913 and 914 and 915 and 916 and 917 and 918 and 919 and 920 and 921 and 922 and 923 and 924 and 925 and 926 and 927 and 928 and 929 and 930 and 931 and 932 and 933 and 934 and 935 and 936 and 937 and 938 and 939 and 940 and 941 and 942 and 943 and 944 and 945 and 946 and 947 and 948 and 949 and 950 and 951 and 952 and 953 and 954 and 955 and 956 and 957 and 958 and 959 and 960 and 961 and 962 and 963 and 964 and 965 and 966 and 967 and 968 and 969 and 970 and 971 and 972 and 973 and 974 and 975 and 976 and 977 and 978 and 979 and 980 and 981 and 982 and 983 and 984 and 985 and 986 and 987 and 988 and 989 and 990 and 991 and 992 and 993 and 994 and 995 and 996 and 997 and 998 and 999 and 1000

IMPORTANT: If item 21 is marked on item 18 showing any injury, or other traumatic event, the medical examiner must be notified.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, CREMATION, TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 90391

1. FOR STATE REGISTRAR										20. DATE KNOWN OF DEATH ESTIMATED Jan 16 1987 7:30 PM									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM OLIVER DUNN JR.										21. DATE PRONOUNCED DEAD January 16 1987 7:30 PM									
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 7--14--05		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											
9. CITY OR TOWN OF DEATH Towson				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF SUCH AS CITY, ST. OR STREET ADDRESS) St. Joseph Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bank Examiner				12b. KIND OF BUSINESS OR INDUSTRY St. of Md.							
13a. STATE Maryland										13b. COUNTY Baltimore									
14. FATHER'S NAME FIRST MIDDLE LAST William Oliver Dunn Sr.										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Levering									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No										16b. SOCIAL SECURITY NO. 220-03-9395									
17. INFORMANT ADDRESS Susan Jackson 743 E. Lake Ave. 21212																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cadaveric Arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>HSCD</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5+ yrs</i>																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19									
21c. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK										21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)									
21e. LOCATION STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																			
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i> M.D. Deputy MEDICAL EXAMINER										DATE SIGNED 1/17/87									
EXAMINER'S NAME (TYPE OR PRINT) Charles F. O'Donnell										ADDRESS 7501 York Road 21204									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE 1-20-87									
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge										23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville Baltimore Maryland									
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home 6500 York Road 21212										25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 20 1987 <i>John T. ...</i>									

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "of", "the", "and" are visible.]

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042463 FEB

DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 00398

1- FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		ESTIMATED	MONTH	DAY	YEAR	2b. HOUR
		CHRISTOPHER R. DUNN					2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR
3 SEX	4 RACE	5. DATE OF BIRTH		MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.				
MALE	WHITE	Jan. 21 1971		11	6		YRS.	MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
North Carolina		U.S.A.						BALTIMORE COUNTY					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
TOWSON		ST. JOSEPH HOSPITAL				STUDENT		EDUCATION					
13a. STATE		13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MARYLAND		BALTIMORE		21234		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8419 OAKLEIGH RD. 21234					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
ERNEST		LAURA E. DENNIS											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
NO		218-84-4211		Laura E. Fritze		8419 Oakleigh Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <i>Anoxic Encephalopathy</i>													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.													
(b) <i>from Hanging</i>													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
		10 P.M. Jan 21 1987		Hung Self									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE			
		At Home		8419 Oakleigh Rd		Baltimore		Maryland					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i> (TYPE OR PRINT)													DATE SIGNED 1/30/87
EXAMINER'S NAME (TYPE OR PRINT) CHARLES F. O'DONNELL, MD													ADDRESS 7501 YORK RD. TOWSON, MD. 21204
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE	
BURIAL		FEB. 2, '87		St. Paul's Lutheran		Baltimore		Maryland					
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
WILLIAM E. JOHNSON		JAN 30 1987		Julia Gordon									

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042475 FEB - 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 00399

1. DECEASED NAME (TYPE OR PRINT) James Thomas DUNN		2a. DATE OF DEATH MONTH DAY YEAR 11/29/87		2b. HOUR 0812 (A M)
3. SEX MALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Mar 18, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD
10. CITY OR TOWN OF DEATH Randallstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore Co. Gen. Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager	12b. KIND OF BUSINESS OR INDUSTRY Sugar
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.		13b. COUNTY Balto.	13c. CITY OR TOWN Reisterstown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST John W. Dunn		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Louise Holmes		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-09-5765		17. INFORMANT ADDRESS Mary Ann Dunn 1512 OAKLAND Rd. Reisterstown, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Uremia, Diabetes Mellitus - Urinary Tract Infection				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 1-27, 1987, to 1-29, 1987, that (I) (we) last saw the deceased alive on 1-27, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE R. Girgis		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-29-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAFAEL Y. GIRGIS		22e. ADDRESS Baltimore County Hosp - Balt		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Jan 31, 1987	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, Balto, Md
24. FUNERAL DIRECTOR NAME H. G. Echhardt		ADDRESS Owings Mills, Md		25a. DATE REC'D. BY REGISTRAR JAN 30 1987
		25b. REGISTRAR'S SIGNATURE Alicia Tindem-Randall		

MEDICAL CERTIFICATION

9
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with a 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified or called.

BP

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042375 JAN

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		7a. DATE OF DEATH		MONTH		DAY		YEAR		7b. HOUR		MIN.	
CATHERINE R. DUNNING								01		20		87		09		10		A.M.	
1. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. UNDER 1 YEAR		8. UNDER 24 HRS.		MONTHS		DAYS		HOURS		MIN.	
FEMALE		WHITE		7 14 1908		28 YRS.													
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
Pa.		USA				Baltimore Co.,												MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OR WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Towson		ST. JOSEPH HOSPITAL		Homemaker															
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. COUNTY		13d. CITY OR TOWN		13e. INSIDE CITY LIMITS?		13f. STREET ADDRESS / ZIP CODE									
Md.						Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		514 Harwood Ave.		21212							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
John Robert Reddy		Ellen Theresa McAndrew																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No		184 05 8302		Mr. Michael Dunning		514 Harwood Ave.		21212											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
PART I. DEATH WAS CAUSED BY						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
IMMEDIATE CAUSE (a)																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																			
(b)																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE IMMEDIATE CAUSE OR CONDITION GIVEN IN PART I (a)																			
Ischemic Heart Disease																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
		HOUR A.M. MONTH DAY YEAR																	
		P.M. 19																	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE									
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>																			
AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>																			
22a. I certify that (I) (this hospital) attended the deceased from		22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED											
1/20/87		E. Nothnagle		M.D.				1/20/87											
22d. PHYSICIAN'S HOME (IF DIFFERENT)		22e. ADDRESS						22f. ZIP CODE											
		2805 Dobson Rd						21204											
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE							
Cremation		1/21/87		Green Mount Cem.		Baltimore, Md.													
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
MITCHELL-WIEDEFELD HOME, INC.		JAN 28 1987		Julia Anderson-Randall															
ADDRESS																			
6500 York Rd.																			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. The funeral director should remove carbon papers. Pages 1 through 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "not viewed," any injury, or other traumatic event, the medical examiner must be notified.

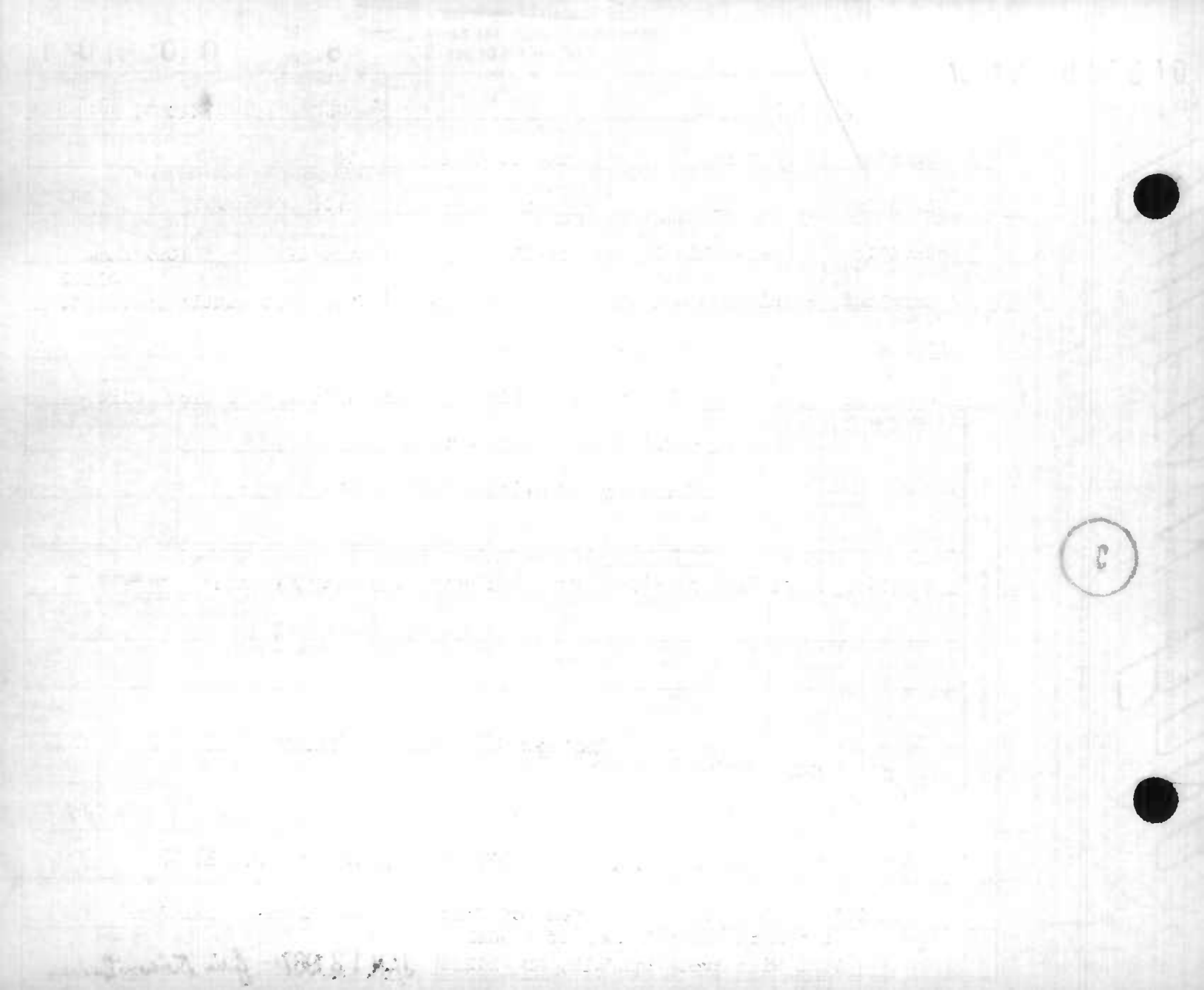
DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 00401
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOURS MIN.	
Virginia EADS		January 6, 1987 (1987)		5:18a M	
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	White	MONTH DAY YEAR	78 YRS.	IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
Virginia	USA		Baltimore County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Rossville	Franklin Square Hospital		Housewife		Own Home
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	
Maryland	Baltimore	Dundalk	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		16b. SOCIAL SECURITY NO.	
William Jamerson		Ava Trent		21222	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
Shirley Adams		7510 Battle Grove Circle		PART 1. DEATH WAS CAUSED BY:	
				IMMEDIATE CAUSE (a) Cardio-respiratory Arrest	
				DUE TO, OR AS A CONSEQUENCE OF	
				(b) Pulmonary Embolism	
				DUE TO, OR AS A CONSEQUENCE OF	
				(c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Congestive Heart Failure with Severe Occlusive Vascular Disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE	
22a. I certify that X (this hospital) attended the deceased from December 29, 1986, to January 6, 1987, that X (we) last saw the deceased alive on January 6, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. X (we) (did) (do not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
A. Minocha		MD		1-6-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
ANIL MINOCHA, M.D.		9000 Franklin Square Dr., 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	23e. STATE
Burial		1-9-87	Gardens of Faith	Baltimore	Maryland
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME Duda-Ruck Funeral Home of Dundalk		ADDRESS 7922 Wise Ave. Dundalk, MD 21222		JAN 12 1987	

Julia Gordon-Ruck



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH1- FOR
STATE
REGISTRAR

87 REG. NO. 00402

DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
Jean		Marcella	Ebersole		January 15, 1987				6:30 PM
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE	7a BALTIMORE CITY OR COUNTY OF DEATH		7b MONTHS		
Female	White	August 14, 1933		53	Baltimore County				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY
Maryland	USA			Baltimore County		Clerk-Typist			Balto. County
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY				
Dundalk	7915 Diehlwood Road		Clerk-Typist		Balto. County				
13a STATE		13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS / ZIP CODE				
Maryland	Baltimore	Dundalk	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	7915 Diehlwood Rd. 21222					
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
John P. Sulewski		Laura Milewski							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS			
No		219-30-2853		Francis H. Ebersole		7915 Diehlwood Rd. 21222			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>hepatic failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic breast cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>carcinoma of the breast</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>none</u> <u>17 months</u> <u>58 months</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>none</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>April 19 87</u> to <u>Jan 15 19 87</u> , that (I) (we) last saw the deceased alive on <u>Jan 8 19 87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
<u>Victor R. Risch MD</u>		MD		<u>Johns Hopkins Oncology Center</u>		<u>1/16/87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Victor R. Risch MD		600 N. Wolfe St Baltimore MD 21205							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		1-19-87		Sacred Heart of Jesus		Baltimore, Maryland			
24 FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Duda-Ruck Funeral Home of Dundalk		7922 Wise Ave. Dundalk, MD 21222		JAN 21 1987		<u>John R. Risch</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate, pages 1 and 2, to the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified of such.

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TO HOSPITAL OR PRESTON ST. BALTIMORE, MARYLAND 21201. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please take it to the funeral home. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, an other traumatic event, the medical examiner must be notified of such.

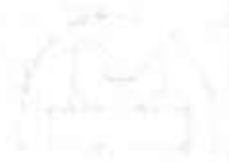
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 00403.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
ANTHONY		F.		EBERT	January 7, 1987				M
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male	White	August 18, 1920			66	YRS		MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland	USA				Baltimore County MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Dundalk	1711 Leslie Rd.			Firebrick Layer		Beth. Steel			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	13d. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
Maryland		Baltimore		Dundalk	13e. STREET ADDRESS / ZIP CODE				
					1711 Leslie Rd. 21222				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
Joseph Ebert		Marcella Kraus							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
Yes		WW II		Adeline M. Ebert 1711 Leslie Rd. 21222					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Long cancer with multiple metastases</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Chronic obstructive pulmonary disease</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>August 1986</i> to <i>near</i> 19 <i>86</i> , that (I) (we) lost saw the deceased alive on <i>Dec 19</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Chi-Shiang Chen</i>					DEGREE <i>M.D.</i>			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
Chi-Shiang Chen, M.D.					100 N. Broadway Balto., MD 21231				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		1-10-87		Moreland		Baltimore Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS					25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Duda-Ruck, Inc. 7922 Wise Ave. Balto., Md 21222					JAN 12 1987		<i>Julia J. J. J.</i>		

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1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. 00404

1. DECEASED NAME (TYPE OR PRINT)		FIRST Louise		MIDDLE F.		LAST Edler		20. DATE KNOWN OF DEATH MONTH DAY YEAR XX 1-4 19 87				26. HOUR a. 8:38 M	
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR MARE 1916		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		21. DATE PRONOUNCED DEAD MONTH DAY YEAR 1-5 19 87		24. HOUR a. 8:38 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Chase		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Eastern Blvd. & Greenbank Rd.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TEACHER		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE PA		13b. COUNTY		13c. CITY OR TOWN WAYNE PA.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 100 WINDEMERE AVE		99999			
14. FATHER'S NAME FIRST MIDDLE LAST ALEXIS IUS FITZPATRICK						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 160-20-6375		17. INFORMANT Henry Fitzpatrick, Jr. 290 Linden Lane							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries 8001 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MONTH DAY YEAR 1:30 P.M. 1-4- 19 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Occupant of train/train collision.							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) railroad tracks		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Eastern Blvd. &, Chase Baltimore MD Greenbank Rd.							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 1-5-87													
ACTUAL SIGNATURE William M. Zane				EXAMINER'S NAME (TYPE OR PRINT) William M. Zane, M.D. ADDRESS 111 Penn St., Balto., MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				23b. DATE 1/9/87		23c. NAME OF CEMETERY OR CREMATORY RAFFERRIS + CO.				23d. LOCATION CITY OR TOWN COUNTY STATE WESTCHESTER PA			
24. FUNERAL DIRECTOR NAME ADDRESS JOHN M. WEBER & SONS INC 401 S CHESTER ST				25a. DATE REC'D. BY REGISTRAR JAN 14 1987				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 34 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL, ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND WELFARE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR OTHER DISPOSITION OF THE BODY.

07/B4 BP _____
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(VR A16 ME (5))

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. Burial is prohibited until removal.

IMPORTANT: If item 21 is marked on item 18, show every injury, or other traumatic event, the medical examiner may be notified at once.

 DHMH - 16 60M 7/B4
 (VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR <u>EDWARD L. J. MOLZ</u>										
1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Molz</u> MIDDLE <u>Edward</u> LAST					2a. DATE OF DEATH MONTH DAY YEAR <u>01 02 87</u>			2b. HOUR <u>7:30 am</u>		
3. SEX <u>Male</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>MAY 22, 1914</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>72</u> YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore County</u> MD.				
10. CITY OR TOWN OF DEATH <u>Towson</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Greater Baltimore Medical Center</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>SELF-EMP</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Doctor</u>		
13a. STATE <u>MARYLAND</u>					13b. COUNTY <u>BALTIMORE</u>		13c. CITY OR TOWN <u>LOCKESSVILLE</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>PETER P. MOLZ</u>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>MARY MOLZ</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>YES</u>					16b. SOCIAL SECURITY NO. <u>W.W.II 219 070236</u>		17. INFORMANT ADDRESS <u>FAMILY RECORDS</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Cirrhosis Of Liver</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>December 28</u> , 19 <u>86</u> , to <u>January 2</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>January 1</u> , 19 <u>87</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Alban B. Bacchus M.D.</u>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>1-2-87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Alban B. Bacchus, M.D.</u>					22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>			23b. DATE <u>1-5-1987</u>		23c. NAME OF CEMETERY OR CREMATORY <u>DUBANSKY VALLEY</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Timonium MARYLAND</u>			
24. FUNERAL DIRECTOR NAME <u>EVANS CHAPEL OF MEMORIES ROAD</u>					25a. DATE REC'D. BY REGISTRAR <u>JAN 8 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia...</u>			

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JAN 8 1951

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deceased be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remain with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DORIS MAY EISENHART					2a. DATE OF DEATH MONTH DAY YEAR 01 05 87		2b. HOUR M		
3 SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 05 29 28		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
12. CITY OR TOWN OF DEATH TOWSON		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST JOSEPHS HOSPITAL				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		15. KIND OF BUSINESS OR INDUSTRY STORE	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY BALTIMORE 13c. CITY OR TOWN PARKVILLE					17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		18. STREET ADDRESS / ZIP CODE 2916 PUTTY HILL AVE 21234		
19. FATHER'S NAME FIRST MIDDLE LAST HERMAN P WERNER			20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LARRIE M. RICHARDSON			21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			
22. SOCIAL SECURITY NO. 216248396			23. INFORMANT ADDRESS FAMILY RECORDS						
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Infarction.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
25a. DATE OF OPERATION		25b. CONDITION FOR WHICH OPERATION WAS PERFORMED				26a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		26b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		27b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
28a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		28b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		28c. LOCATION STREET CITY OR TOWN COUNTY STATE					
29. I certify that (I) (this hospital) attended the deceased from <u>8-18</u> 19 <u>86</u> to <u>11-24</u> 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>11-24</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death <u>86</u>									
30. SIGNATURE <u>A.H. Ghiladi</u>				DEGREE		31. DATE SIGNED 1-5-87		32. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
33. PHYSICIAN'S NAME (TYPE OR PRINT) A.H. GHILADI, M.D.				34. ADDRESS 7600 OSLER Dr. Towson 21204					
35a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		35b. DATE 1-9-1987		35c. NAME OF CEMETERY OR CREMATORY DULANEY VALLEY		35d. LOCATION CITY OR TOWN COUNTY STATE Timonium BALTO. MD.			
36. FUNERAL DIRECTOR NAME ADDRESS EVANS CHAPEL OF MEMORIES ROAD 8800 HARFORD				37. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 8 1987 Julia Gordon-Randall					

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UNITED STATES DEPARTMENT OF JUSTICE

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042058 JAN 20 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 00407

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
Ray E. Elmore Sr.		Male		White	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	
9 MONTH 14 DAY 1923		62 YRS		North Carolina USA	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
		Baltimore County MD.		Dundalk	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
3503 Dunhaven Rd. 21222					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS / ZIP CODE	
13a. STATE 13b. COUNTY 13c. CITY OR TOWN		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3503 Dunhaven Rd. 21222	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Thurman Elmore		Bertha		No	
16b. SOCIAL SECURITY NO.		17. INFORMANT		17. ADDRESS	
243-22-9009		Richard Elmore		31 Portship Rd. 21222	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>acute myocardial infarction.</u>				? minutes	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>H.E.A.S.C.V.D.</u>				years.	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Recurrent C.H.F.</u>				years	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Recurrent Deep Vein Thrombosis.</u>				one year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 13</u> 19 <u>79</u> to <u>Jan 24</u> 19 <u>87</u> , that (I) last saw the deceased alive on <u>June 6</u> 19 <u>86</u> , and that in (my) last opinion death occurred on the date and hour and from the causes stated above, (I) viewed (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>ATAOLLAH GOLPIRA</u>		M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		1-27-1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
ATAOLLAH GOLPIRA		3029 Dundalk Ave. Balto, Md. 21222			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		1/27/87		Gardens of Daith	
				23d. LOCATION	
				CITY OR TOWN COUNTY STATE	
				Baltimore, Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME Connelly Funeral Home ADDRESS Dundalk		JAN 28 1987		<u>Julia Anderson</u>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. This certificate, however, must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 00408

1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT) DALLAS ELSWICK										2b. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 1 10 19 87		2c. HOUR 1000	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 8, 1930		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 10 19 87		2d. HOUR 1220			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1919 Jasmine Rd.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Crane Operator		12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel					
13a. STATE Maryland		13b. CITY OR TOWN Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1919 Jasmine Rd. 21222							
14. FATHER'S NAME FIRST MIDDLE LAST Isaac Elswick				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Webb											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 231-36-8086		17. INFORMANT ADDRESS Dolly D. Elswick 1919 Jasmine Rd. 21222									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Chronic hypertensive cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE J. Crossan O'Donovan				TIME (SPECIFY) Deputy				DATE SIGNED 1/10/87							
EXAMINER'S NAME (TYPE OR PRINT) J. CROSSAN O'DONOVAN				ADDRESS 2112 Dundalk Ave., Balto., Md. 21222											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1-13-86		23c. NAME OF CEMETERY OR CREMATORY Holly Hill				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk				ADDRESS 7922 Wise Ave. Dundalk, MD 21222				25a. DATE REC'D. BY REGISTRAR JAN 12 1987		25b. REGISTRAR'S SIGNATURE Julia Denton					

042371 JAN 30 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT)		FIRST DAVID	MIDDLE LEA	LAST EMBRY	2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR		
David				Embry	1 21 87		1 25 M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male	White	10 24 41		45		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	U.S. U.S.A.			County Baltimore County MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Towson	St. Joseph's Hosp.		Manager		Hotel				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?				
13a. STATE 13b. COUNTY 13c. CITY OR TOWN					13e. STREET ADDRESS / ZIP CODE				
Maryland Baltimore Towson					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 602 Fairway Dr. 21204				
14. FATHER'S NAME FIRST ROBERT MIDDLE CAMPBELL LAST EMBRY					15. MOTHER'S MAIDEN NAME FRANCES COCKERHAM				
Robert					SR.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.				
No					218-40-4603				
17. INFORMANT					ADDRESS				
					R.C. EMBRY SR. 602 Fairway Dr. 21204				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic undifferentiated Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yr.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Negative determination, Malabsorption</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1985</u> 19 <u>1/21</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>1/21</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Arthur A. Scarpick MD</u>				DEGREE MD				22c. DATE SIGNED 1/21/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
Arthur A. Scarpick MD				7620 York Rd Baltimore MD 21117					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation		1-22-87		Greenmount		Baltimore City Baltimore County Maryland			
24. FUNERAL DIRECTOR NAME				25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Mitchell-Wiedefeld Home 6500 York Road 21212				JAN 28 1987					

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

00490

1. DECEASED NAME (TYPE OR PRINT) Helen Agnes EMKEY			2a. DATE OF DEATH MONTH DAY YEAR January 1, 1987		2b. HOUR 10:20pm	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 19 1909		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. MONTHS DAYS HOURS MIN.		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY FOOD PROCESSING				
13a. STATE MD.		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		
14. FATHER'S NAME FIRST MIDDLE LAST JOHN FRISKEY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AMELIA SMITH		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-01-2842		17. INFORMANT ADDRESS JOHN J. EMKEY (HUSBAND) SAME ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Anoxic Encephalopathy DUE TO, OR AS A CONSEQUENCE OF (c) Ventricular Fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)		
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from December 30, 1986 , to January 1, 1987 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on January 1, 1987 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (do not) view the body after death.						
22b. SIGNATURE <i>Gouni</i> DEGREE M.D.		22c. DATE SIGNED 1-1-87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) I. Gouni, M.D.		
22e. ADDRESS 9000 Franklin Square Dr., 21237						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/5/87		23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER		
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.						
24. FUNERAL DIRECTOR NAME ADDRESS SCHIMUNEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213		25a. DATE REC'D. BY REGISTRAR JAN 5 1987		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy, page 1, which should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified of this.

BP

040233 JAN 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

REG. NO.

00411

1. DECEASED NAME (TYPE OR PRINT) Leo Pershing Englar			2a. DATE OF DEATH MONTH DAY YEAR January 1 1987			2b. HOUR M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR NOV 29 1918		6. AGE (IN YEARS LAST BIRTHDAY) 68		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Eastpoint		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 421 Scarsdale Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired-Carpenter		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Balto.		13c. CITY OR TOWN Eastpoint		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Frank Englar		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betty Fox		16. ADDRESS 421 Scarsdale Road 21224					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT Donald Englar 421 Scarsdale Road 21224					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediately</u>	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>NOODULAR Poorly differentiated lymphocytic/histiocytic</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>6 years</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>a</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Mack Mabey MD</u>			DEGREE			22c. DATE SIGNED 1/2/87		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) MACK MABEY MD			22f. ADDRESS 2-121 ONCOLOGY CENTER JHMS BALTIMORE MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/3/87		23c. NAME OF CEMETERY OR CREMATORY OakLawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		
24. FUNERAL DIRECTOR Connelly Funeral Home 300 Race Ave. 21221						25a. DATE REC'D. BY REGISTRAR JAN 6 1987		25b. REGISTRAR'S SIGNATURE <u>John J. ...</u>	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, this must be certified on page 3.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card and page 3 and 4 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

040193 JAN 8 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. This permit remove carbon papers. Pages 1 and 2 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1, the medical examiner must be notified of the death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 00412	
1. DECEASED NAME (TYPE OR PRINT) Elizabeth Delia Ensor			2a. DATE OF DEATH MONTH DAY YEAR 1/4/87			2b. HOUR 11:45 M					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 25 1911		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St Joseph Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Head Teller		12b. KIND OF BUSINESS OR INDUSTRY Banking			
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Timonium		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 44 Norwick Cir., 21093		
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Leo Concannon					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ann Reilly						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-14-1203		17. INFORMANT ADDRESS Barbara E. Ensor, 1020 Woodson Rd., 21212						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiopulmonary arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Pneumonia											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Coronary artery disease, Long term blood pressure											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from refr 19 86 to 1/5 19 87 , that (I) (we) last saw the deceased alive on above , (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE					DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 21204	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. Reiche					22e. ADDRESS 2500 Talbot Valley Rd. Towson						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/8/87		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Timonium Balto. Md.				
24. FUNERAL DIRECTOR NAME ADDRESS Martin D. Lawson, 10 W. Padonia Rd.					25a. DATE REC'D. BY REGISTRAR JAN 7 1987		25b. REGISTRAR'S SIGNATURE Julia E. ...				

BP

11-11-11

11-11-11

11-11-11



UNK. #87--6

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			ESTIMATED			MONTH DAY YEAR			2b. HOUR				
JEROME			EDWARD			EVANS			<input checked="" type="checkbox"/>			1 4 1987			M				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR		IF UNDER 24 HRS		7c. DATE PRONOUNCED DEAD			2d. HOUR				
MALE		WHITE		JUNE 30 1951		35 YRS		MONTHS DAYS		HOURS MIN		1 5 1987			12:33 AM				
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH				MD			
MARYLAND				U.S.A.								Baltimore County							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Chase				Eastern Blvd. & Greenbank Rd.				Engineer				AMTRAK							
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS			
MARYLAND				BALTIMORE				OVERSEA				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13 MAPLE AVE			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME															
CLARENCE A. EVANS				DOROTHY E. SCHMIDT															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS							
NO				215 56 1045				FAMILY RECORDS											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) Multiple injuries																			
8000																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:																			
DUE TO, OR AS A CONSEQUENCE OF																			
DUE TO, OR AS A CONSEQUENCE OF																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?			
																YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
				1:30 P.M. 1-4- 1987				Occupant of train/train collision.											
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION				CITY OR TOWN				STATE			
				railroad tracks				Eastern Blvd. & Greenbank Rd.				Chase				Baltimore MD			
22a. I certify that I took charge of the remains described above, held on death resulted from <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																			
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED											
Charles P. Kokes, M.D.				M.D. Assistant				MEDICAL EXAMINER				1-5-87							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
Charles P. Kokes, M.D.				111 Penn St., Balto., MD				21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (CITY OR TOWN)				COUNTY STATE			
BURIAL				1-8-1987				PARKWOOD CEM.				PARKVILLE				BALTO. MARYLAND			
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
EVANS				8800 HARFORD				JAN 8 1987				Julia Seiden-Rudner							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM WM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Two pleats remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|---|--|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
WILLIAM LAWSON EVANS | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1 9 1987 | | | 2b. HOUR
9:15 PM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 9 1924 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 9. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | | | |
| 12. CITY OR TOWN OF DEATH
Woodlawn | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1625 Ingleside Ave. #8 | | | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Car Inspector | | 15. KIND OF BUSINESS OR INDUSTRY
Railroad | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Woodlawn | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Hance Lawson Evans | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rose Lillian Christopher | | | 16. STREET ADDRESS / ZIP CODE
1625 Ingleside Ave. #8 21207 | | | |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | 18. IF YES, GIVE WAR OR DATES
WW II | | 19. SOCIAL SECURITY NO.
218-16-7357 | | 20. INFORMANT
Donna Wright 1623 Harness Lane San Antonio Texas 78227 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>LUNG CANCER, ALVEOLAR CELL</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>CHRONIC LUNG DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 YR |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MAR 19 86</u> to <u>PRISON</u> 19____, that (I) (we) lost
saw the deceased alive on <u>12 12 19 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>G. Cohen</u> | | | 22c. ADDRESS
<u>711 W. 4th St. BALTO MD.</u> | | | 22d. DATE SIGNED
1/10/87 | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Gary Cohen | | | 22f. ADDRESS
<u>711 W. 4th St. BALTO MD.</u> | | | 22g. DATE SIGNED
1/10/87 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
1/ 13/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Sunny Ridge Memorial Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crisfield Md. | | |
| 24. FUNERAL DIRECTOR
NAME
1630 Edmondson Ave. Catonsville, Md. 21228
Leroy M. & Russell C. Witzke Funeral Home | | | | | | 25. DATE REC'D. BY REGISTRAR
JAN 16 1987 | | 25. REGISTRAR'S SIGNATURE
<u>Julia Benson-Rubina</u> | |

U. S. DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

3

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that all death certificates be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove captioned papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. Q0415

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
WILLIAM E. EVERETT | | 2a. DATE OF DEATH MONTH DAY YEAR
1 20 87 | | 2b. HOUR
14 50 | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Feb. 20, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.
68 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Michigan | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore Co. MD. | |
| 10. CITY OR TOWN OF DEATH
Randallstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Balto. Co. Gen. Hospt. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Mechanic | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Owings Mills | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Hugh Everett | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Ethel Bender | | 13e. STREET ADDRESS / ZIP CODE
137 S. Ritters La. 21117 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO. (IF GIV. WAR OR DATES)
WW 2 | | 17. INFORMANT ADDRESS
Mrs. Annabell Everett Owings Mills, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ELECTROMECHANICAL DISSOCIATION
DUE TO, OR AS A CONSEQUENCE OF
(b) MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
RECURRENT VENT. FIB; G-I Bleeding; Aortic Atherosclerosis | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
HABIB A. SYED | | 22c. DEGREE
M.D. | | 22d. DATE SIGNED
1/20/87 | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
HABIB A. SYED | | 22f. ADDRESS
BALTIMORE COUNTY GEN HOSP. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/23, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest Vet. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Owings Mills, Md. | |
| 24. FUNERAL DIRECTOR NAME
Eline Funeral Home | | | | 24b. ADDRESS
Reisterstown, Md. 21136 | | 25a. DATE REC'D BY REGISTRAR
JAN 21 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Julia Borden | | | |

02-11-13 25

10-18-13

10-18-13

10-18-13

10-18-13

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10-18-13

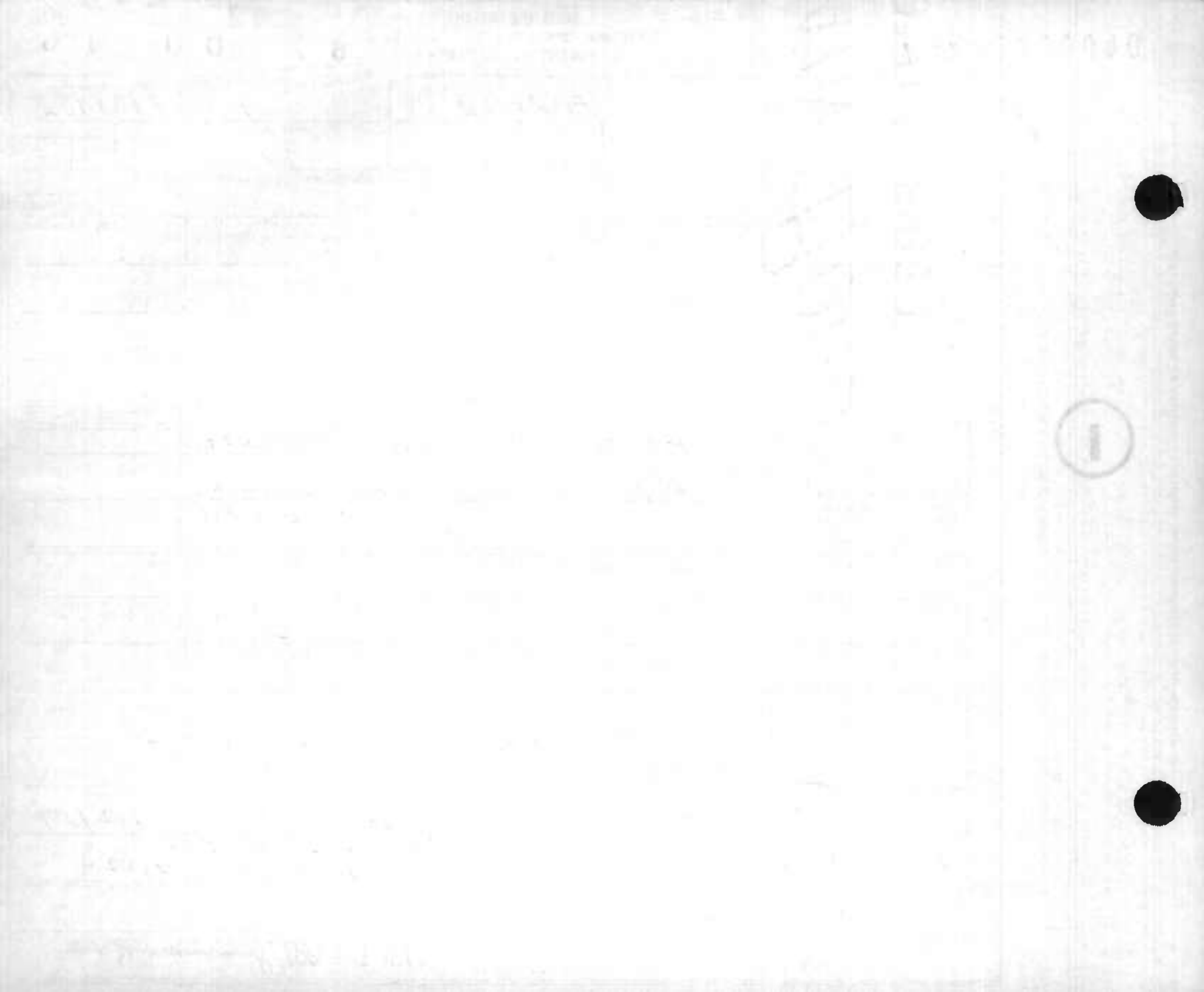
10-18-13

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 00410
REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JOSEPH - FARMER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1 12 87 | | | 2b. HOUR
1:10 AM | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 16 96 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Randallstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Balto. County Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Claims | | 12b. KIND OF BUSINESS OR INDUSTRY
Insurance | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | 13b. CITY OR TOWN
Balto. | | 13c. STREET ADDRESS / ZIP CODE
2603 Purnell Dr. 21207 | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel E. Farmer | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Etta Hunter | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1917-19 | | 17. INFORMANT
ADDRESS
Ms. Alice B. Farmer - Same as #13 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>/</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/11/87</u> , 19 <u>87</u> , to <u>1/12/87</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>1/12/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
DEGREE
<u>Archie Luma Chiqua M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
1/12/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A.K. CHOPRA | | | | | 22e. ADDRESS
3455 WILKENS AVE
BALTIMORE MD 21229 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | | 23b. DATE
1-12-87 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| 24. FUNERAL DIRECTOR
NAME
Anatomy Board | | | | | ADDRESS
Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR
JAN 14 1987 | | |
| 25b. REGISTRAR'S SIGNATURE
<u>Jana Davidson</u> | | | | | | | | | |



040887 JAN 16 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 00417

| | | | | |
|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) SALVATORE | | 2a. DATE OF DEATH
MONTH JAN DAY 10 YEAR 1987 | | 2b. HOUR
M. |
| 3. SEX
M | 4. RACE
W | 5. DATE OF BIRTH
MONTH NOV DAY 10 YEAR 1910 | | 6. AGE
(IN YEARS LAST BIRTHDAY)
76 YRS. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
ITALY | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO COUNTY MD. |
| 10. CITY OR TOWN OF DEATH
CATONSVILLE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
924 COLERIDGE | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MACHINEIST | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY BALTO 13c. CITY OR TOWN CATONSVILLE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
924 COLERIDGE RD 21228 |
| 14. FATHER'S NAME
FIRST GIUSEPPE MIDDLE FAZIO LAST ROSA | | 15. MOTHER'S MAIDEN NAME
FIRST MARSLIA ADDRESS 924 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
216-42-7204 | | 17. INFORMANT
CONCETTA FAZIO COLERIDGE RD |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bladder Cancer
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from 12 19 87 to 7 19 87 , that (I) (we) last saw the deceased alive on 1/13 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we did not) view the body after death. | | | | |
| 22b. SIGNATURE
Philip Kowit | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/14/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Philip Kowit | | 22e. ADDRESS
606 Hammond Lane Baltimore | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
ENTOMBMENT | | 23b. DATE
1/13/87 | | 23c. NAME OF CEMETERY OR CREMATORY
DRUID RIDGE |
| 23d. LOCATION
(CITY OR TOWN, COUNTY, STATE)
BALTIMORE MD | | 23e. DATE REC'D. BY REGISTRAR
JAN 14 1987 | | |
| 24. FUNERAL DIRECTOR
NAME
EDWARD J. WEBER FH | | ADDRESS
EDMONSON AV | | 25b. REGISTRAR'S SIGNATURE
John Benson-Budner |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body. The medical certificate must be retained at all times.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical certificate must be retained at all times.

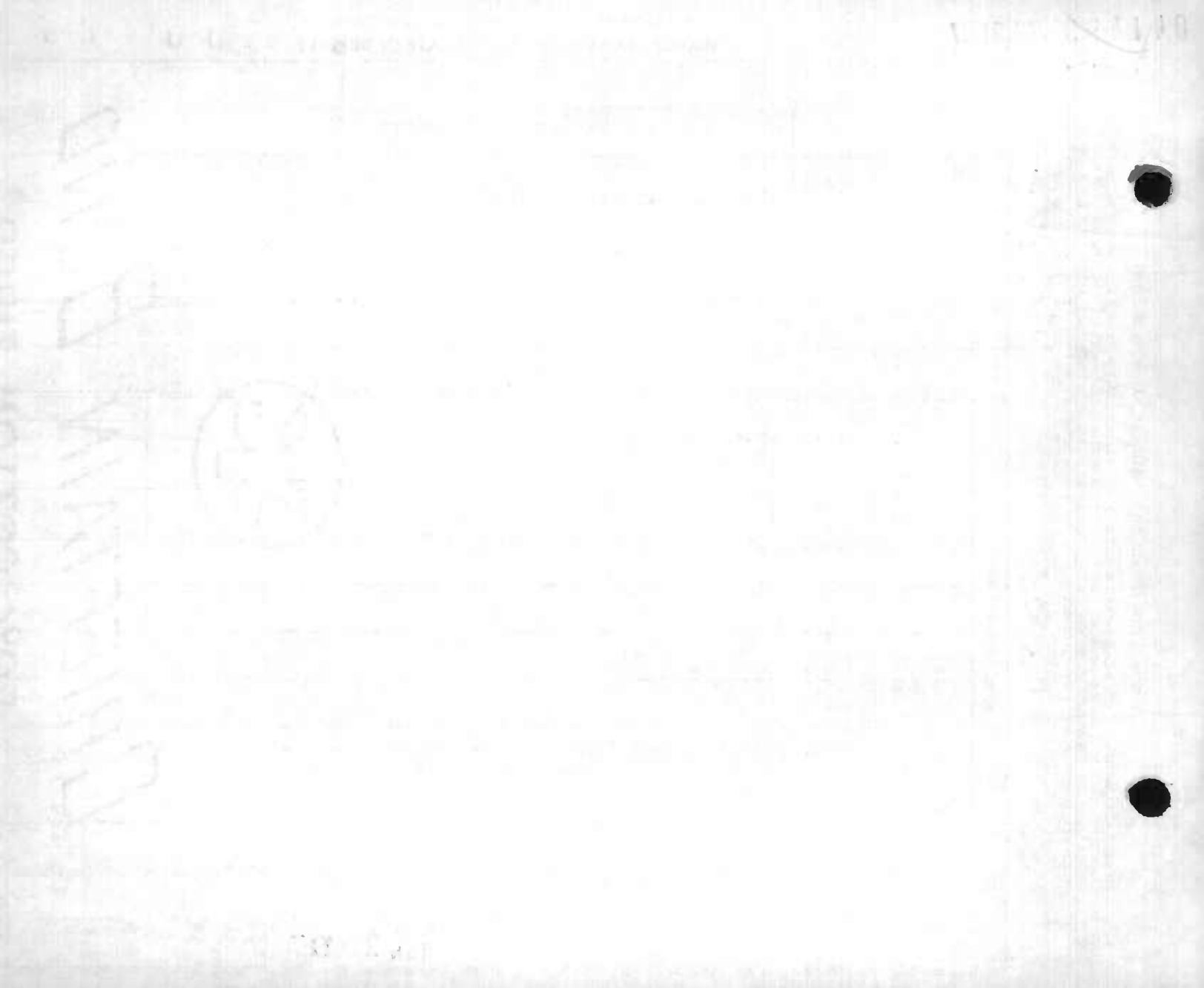
**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **00418**

| | | | | | | | | | | | | | | | | | | | |
|---|--|-------------|--|---|--|-------------------|--|--|--|------------------|--|--|--|-----------|--|-----------------------------------|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | ESTIMATED | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| KELLY | | R. | | FILLIUS | | | | <input checked="" type="checkbox"/> 1 | | 18 | | 19 | | 87 | | | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| Fem. | | CAu. | | 3 25 66 | | 20 YRS. | | | | | | 1 18 19 87 | | 1P | | M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Md. | | | | U.S.A. | | | | | | | | Baltimore County MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BALto. | | | | 11110 Pulaski Highway | | | | | | | | Cosmotologist - Hair Cuttery | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET ADDRESS | | | |
| Md. | | | | Balto. | | | | BALto. | | | | YES | | | | 5704 Utrecht Rd. 21206 | | | |
| 14. FATHER'S NAME | | | | MIDDLE | | | | LAST | | | | 15. MOTHER'S MAIDEN NAME | | | | MIDDLE | | | |
| James | | | | C. | | | | Fillius | | | | Virginia | | | | Griffin | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | | | | | | | |
| no | | | | 213-70-2149 | | | | Virginia L. Teufer | | | | 5704 Utrecht Rd. 21206 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hanging
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.
Superficial cuts to arms and wrists | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | | | 20. AUTOPSY? | |
| | | | | | | | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
1-18- 1987 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject hanged self. | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
motel | | | | 21f. LOCATION
STREET
11110 Pulaski Highway | | | | CITY OR TOWN
Baltimore, MD | | | | COUNTY
Baltimore, MD | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Charles P. Kokes</i> | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | | | | | | | | | | | DATE SIGNED 1-19-87 | |
| EXAMINER'S NAME (TYPE OR PRINT)
Charles P. Kokes, M.D. | | | | ADDRESS
111 Pnen St., Balto., MD 21201 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
1-21-87 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cem. | | | | 23d. LOCATION
CITY OR TOWN
BALto. | | | | COUNTY
Baltimore | | STATE
MD | |
| 24. FUNERAL DIRECTOR
NAME
John C. Miller Inc. | | | | ADDRESS
6415 Belair Rd. 21206 | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 20 1987 | | | | 25b. REGISTRAR'S SIGNATURE
<i>Julia D. ...</i> | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM #M 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove chapters 1 and 2, which should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|---|--|--|--|---|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Henry W. FISCHER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
January 11, 1987 | | | 2b. HOUR
11:05p | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 11, 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto. Co. Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Rossville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Franklin Square Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Horticulture | | 12b. KIND OF BUSINESS OR INDUSTRY
Self-Employed | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
kingsville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
8227 Green House Rd. 21087 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ernst R. Fischer | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sophia BERK | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | | |
| 16b. SOCIAL SECURITY NO.
213-10-8367 | | | 17. INFORMANT
Mrs. Marie A. Fischer, Kingsville, Md. | | | ADDRESS 8227 Green House Rd. 21087 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Inferior Myocardial Infarction and Cardiogenic Shock
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from January 6 , 19 87 , to January 11 , 19 87 , that (X) (we) last saw the deceased alive on January 11 , 19 87 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (X) (X) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Sarah L Owens | | | DEGREE
M.D. | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
1-11-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Sarah L. Owens, M.D. | | | 22e. ADDRESS
9000 Franklin Square Dr. 21237 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
1-15-1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Zion Luth. Ch. Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Stemmers Run Balto. Md. | | | |
| 24. FUNERAL DIRECTOR
Lassalle FH 11750 Belair Rd 21087 | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
JAN 14 1987 Julia Borden-Rudick | | | | | | | |

BP. _____

1881

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041646 JAN 21 1987

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 00420
REG. NO.

| | | | | | |
|---|---|--|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Nietz M Fishpaw | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1-19-1987 | | 2b. HOUR
1725 PM |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
9 28 1899 | 6. AGE (IN YEARS LAST BIRTHDAY)
87 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | | |
| 10. CITY OR TOWN OF DEATH
Randallstown | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Baltimore County General Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Bwings Mills | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Stran | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Jean Welch | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
220-05-7239 | 17. INFORMANT
ADDRESS
Sandra J. Raver (same as above) | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory arrest.</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Pneumonia Right lower lobe</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Amyotrophic Lateral Sclerosis.</u> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-15, 1987</u> , to <u>1-19, 1987</u> , that (I) (we) last saw the deceased alive on <u>1-19, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Allen J. Chircus M.D.</u> | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>1-19-87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Allen J. Chircus M.D.</u> | | 22e. ADDRESS
<u>Baltimore County General Hosp</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
1-23-87 | 23c. NAME OF CEMETERY OR CREMATORY
Grace Methodist Cem. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Reisterstown Balt. Md. | | |
| 24. FUNERAL DIRECTOR
NAME
Eline Funeral Home | | ADDRESS
Reisterstown, Md. | | 25a. DATE REC'D. BY REGISTRAR
JAN 21 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>John Anderson-Randall</u> | |

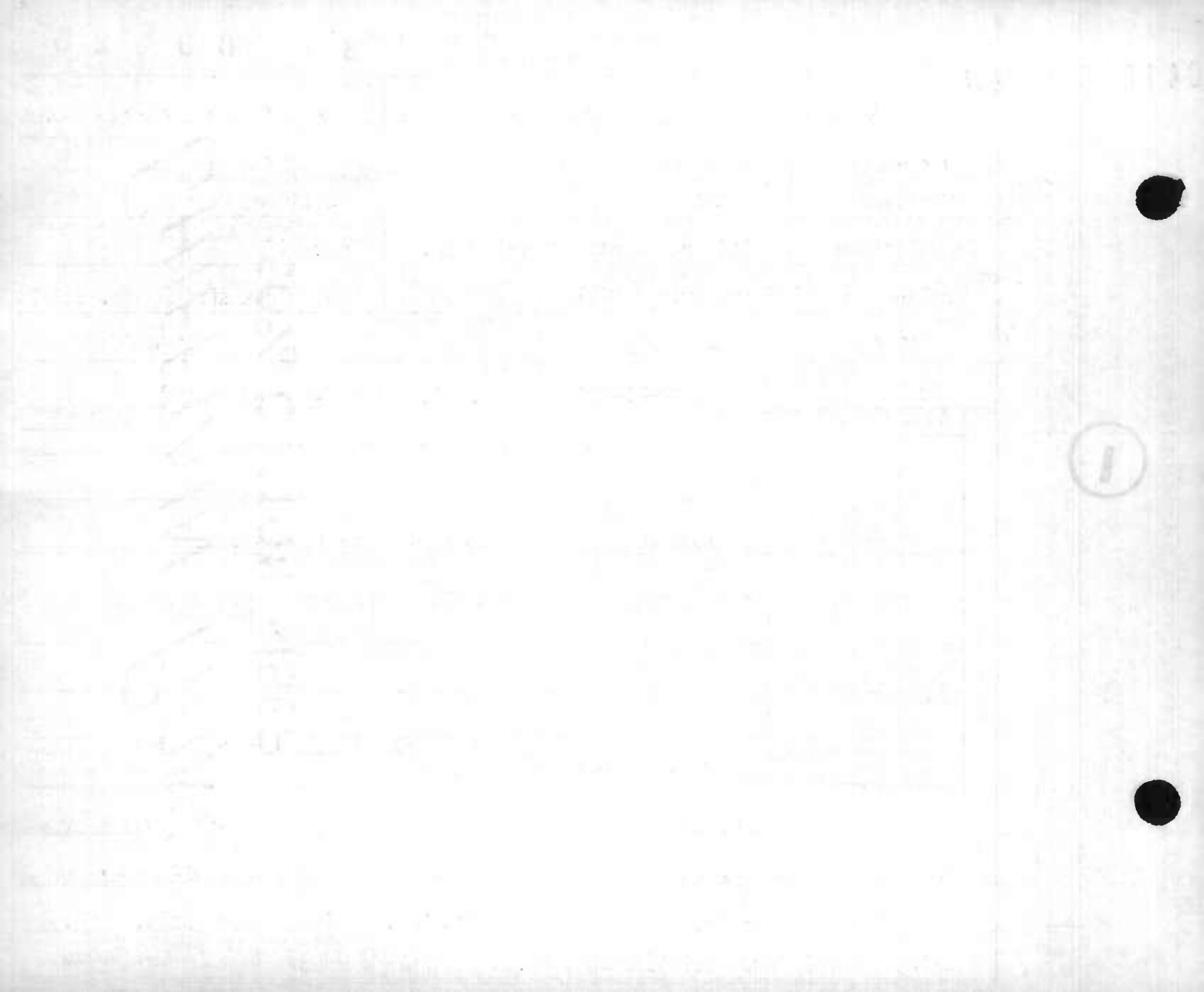
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove container papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 8 shows any injury, or other traumatic event, the medical examiner must be notified.

BP _____



BP

DHMM - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 87 00421 | | | |
|--|--|--|--|--|--|---|--|---|--|--|--|--------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
<i>Helen J Flatman</i> | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>01 14 87</i> | | 2b. HOUR
<i>0931</i> ^A | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR
<i>06 01 34</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>52</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>England</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>England</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Balto. County</i> MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Randallstown</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Balto. County Hosp.</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Secretary</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>School</i> | | | | | |
| 13a. STATE
<i>Md.</i> | | 13b. COUNTY
<i>Balto.</i> | | 13c. CITY OR TOWN
<i>McDonough</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<i>#3 Bird Apts. 21208</i> | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>Edward P. Flatman</i> | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>Winifred Hall</i> | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>213-46-0704</i> | | 17. INFORMANT ADDRESS
<i>Mrs. Helen Seifert McDonough, Md.</i> | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>coronary atherosclerosis</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>sudden</i> | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (a)
<i>Ca of breast postoperative</i> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<i>April 5, 87</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Ca of breast</i> | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/14/86</i> to <i>1/14/87</i> , that (I) (we) last saw the deceased alive on <i>1/14/87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>William F. Penner</i> | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
<i>1/14/87</i> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>William F. Penner</i> | | 22e. ADDRESS
<i>3222 ST. Paul ST</i> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Removal</i> | | 23b. DATE
<i>1-15-87</i> | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| 24. FUNERAL DIRECTOR NAME
<i>Anatomy Board</i> | | | | | | ADDRESS
<i>Balto., Md.</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>JAN 21 1987</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | |

1937 11 10

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 10th inst. and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,
Yours very truly,
[Signature]

Very truly yours,
[Signature]

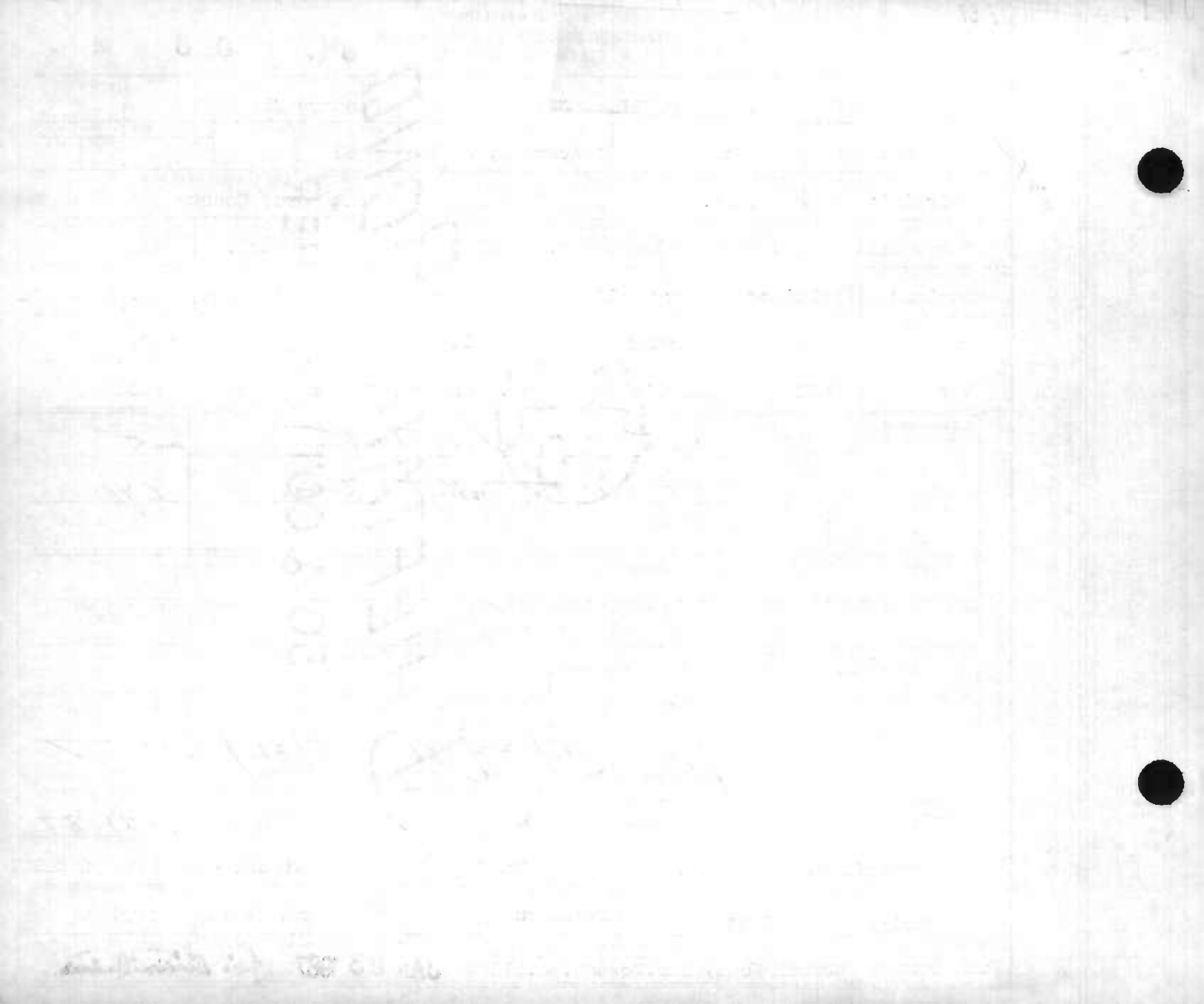
Very truly yours,
[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please (remove carbon paper) return this page to the funeral director. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 87 00422 | |
|---|--|---|--|--|---|
| 1- FOR STATE REGISTRAR | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FRANK E. FOSTER, JR. | | | 2a. DATE OF DEATH MONTH DAY YEAR
January 21, 1987 | | 2b. HOUR
M |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH MONTH DAY YEAR
January 1, 1924 | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County MD. | | |
| 10. CITY OR TOWN OF DEATH
Perry Hall | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
#3 Canoga Place, Apt. 1A 21236 | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Service Tech. | 12b. KIND OF BUSINESS OR INDUSTRY
Sears | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Perry Hall | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Frank Ernest Foster | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Annle Maud Kanode | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | 16b. SOCIAL SECURITY NO.
219-12-7860 | 17. INFORMANT ADDRESS
Mrs. Emily C. Foster, same as #13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>6 yrs</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/22/87</u> to <u>1/21/87</u> , that (I) (we) last saw the deceased alive on <u>11/11/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (they) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Francis T. Daly</u> | DEGREE
<u>M.D.</u> | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>1.21.87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Francis T. Daly, M.D. | | 22e. ADDRESS
St. Joseph's Professional Building, Suite 201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
1-23-87 | 23c. NAME OF CEMETERY OR CREMATORY
Crestlawn | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Howard, County Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
Ruck Towson Funeral Home, Inc. Towson, Md. 21204 | | 25a. DATE REC'D. BY REGISTRAR
JAN 23 1987 | 25b. REGISTRAR'S SIGNATURE
<u>Julia Helen Ruck</u> | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B, show any injury or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/B4
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 00423 | |
|--|---|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
LOIS B. FOSTER | | | 2a. DATE OF DEATH MONTH DAY YEAR
JAN 12, 1987 | | 2b. HOUR MIN.
12 P.M. |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH MONTH DAY YEAR
July 11, 1934 | 6. AGE (IN YEARS LAST BIRTHDAY)
52 YRS | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH
TOWSON | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. JOSEPH HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Lutherville |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Thomas F. Brown, Jr. | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Lois Underhill | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
577-52-9325 | | 17. INFORMANT ADDRESS
Mr. John J. Foster, Jr. same as # 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CIRRHOSIS OF THE LIVER
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that X (this hospital) attended the deceased from 12-26, 1986, to 1-12, 1987, that X (we) last saw the deceased alive on 1-12, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above X (we) (did) (do) view the body after death. | | | | | |
| 22b. SIGNATURE
[Signature] 3.M.D. | | DEGREE | | 22c. DATE SIGNED
1-13-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
REYNALDO ORTUELA-GOMEZ | | 22e. ADDRESS
7620 YORK RD TOWSON 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/15/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley Cem. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Maryland | | 24. FUNERAL DIRECTOR NAME
Ruck Towson Funeral Home, Inc. 1050 York Road | | | |
| 25a. DATE REC'D. BY REGISTRAR
JAN 16 1987 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove co-burial page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the filing of this statement must be notified at once.

JUN 20 1937 *Miss Frederic Lindner*

PAID 10/10/1914

10/10/1914

10/10/1914



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please send the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

043019 FEB 1987

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 00425
REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MIKE FRANGAKIS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1 31 87 | | | 2b. HOUR
9 PM | | | |
| 3. SEX
m Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 14, 1891 | | 6. AGE (IN YEARS LAST BIRTHDAY)
95 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 8. BIRTHPLACE (COUNTRY)
GREECE | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
TOWSON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. JOSEPH HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Steel Worker | | 12b. KIND OF BUSINESS OR INDUSTRY
Steel | |
| 13a. STATE
Maryland | | | 13b. CITY OR TOWN
Baltimore | | 13c. CITY OR TOWN
Phoenix | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Anthony Frangakis | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Kalliope Mastromichalis | | | 13e. STREET ADDRESS / ZIP CODE
3 Collingwood Garth 21131 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
236-03-5531 | | 17. INFORMANT
P. Kalathas | | | ADDRESS
3 Collingwood Garth 21131 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiorespiratory arrest
DUE TO, OR AS A CONSEQUENCE OF (b) multiple organ failure
DUE TO, OR AS A CONSEQUENCE OF (c) failure | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 9a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN IDENTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Pemy Chhim | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PEMY CHHIM | | | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
2-3-87 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Demetrios | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Carney Baltimore Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
Mitchell-Wiedefeld Home | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 4 1987 | | 25b. REGISTRAR'S SIGNATURE
Lia Swenson-Rodgers | |
| ADDRESS
6500 York Road 21212 | | | | | | | | | |

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REG. NO.

FOR
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REGISTRAR

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|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Rose | | 2. DATE OF DEATH
MONTH 1 DAY 19 YEAR 87
9:10 A | |
| 3. SEX
Female | | 4. RACE
Caucasian | |
| 5. DATE OF BIRTH
MONTH 5 DAY 17 YEAR 93 | | 6. AGE (IN YEARS LAST BIRTHDAY)
93 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Trosenfurt, Germany | | 7b. CITIZEN OF WHAT COUNTRY?
USA | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore, County | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Stella Maris Hospice | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Home Maker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. COUNTY | |
| 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
4239 Shamrock Rd. 21206 | | 13f. STREET ADDRESS / ZIP CODE
4239 Shamrock Rd. 21206 | |
| 14. FATHER'S NAME
FIRST Michael MIDDLE Roppelt LAST Roppelt | | 15. MOTHER'S MAIDEN NAME
FIRST Kunigunda MIDDLE Lang LAST Lang | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
216-46-0550 | |
| 17. INFORMANT
John P. Roppelt | | ADDRESS
4231 Belmar Ave.-21206 | |
| 18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Lung
DUE TO, OR AS A CONSEQUENCE OF
(b) CHE
DUE TO, OR AS A CONSEQUENCE OF
(c) CHE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH 11 DAY 19 YEAR 87
P.M. | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET 2300 Dulaney Valley Rd. CITY OR TOWN Towson COUNTY Md. STATE Md. | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/6 , 19 85 , to 1/19 , 19 87 , that (I) (we) lost saw the deceased alive on 1/17 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
Dr. E. Naluda DEGREE MD | |
| 22c. DATE SIGNED
1-19-87 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. E. Naluda | |
| 22e. ADDRESS
2300 Dulaney Valley Rd. Towson, Md. 21204 | | 22f. ADDRESS
2300 Dulaney Valley Rd. Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1-22-87 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Holy REdeemer Cem. | | 23d. LOCATION
CITY OR TOWN Balto. Md. COUNTY Md. STATE Md. | |
| 24. FUNERAL DIRECTOR
NAME
John C. Miller, Inc., -6415 Belair Rd. ---21206 | | 25. DATE REC'D. BY REGISTRAR
JAN 20 1987 | |
| 25a. REGISTRAR'S SIGNATURE
Julia Benson-Randall | | 25b. REGISTRAR'S SIGNATURE
Julia Benson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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Page 4 may be returned by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach this paper to the certificate and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other unusual event, the medical examiner must be notified at 1-800-368-2222.

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 1 11 87 | | 6:50p.m. | |
| CHARLES ALLEN TALBOTT FUCHS | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| MALE | | WHITE | | MONTH DAY YEAR
3 25 15 | | 71 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Maryland | | U.S.A. | | | | Baltimore County MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Catonsville | | Summit Nursing Home | | Machinist | | Civil Service | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Maryland | | Howard | | Elkridge | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS / ZIP CODE | | | |
| FIRST MIDDLE LAST
Henry Fuchs | | FIRST MIDDLE LAST
Anna Virginia Talbott | | 5858 Main Street 21227 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| NO | | 213-28-1894 | | C. Alieene Fuchs | | 5858 Main Street 21227 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Massive Cerebral Vascular Accident</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Hypertensive Cardiovascular Disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c)
<u>1. History of previous cerebral vascular accident 2. Diabetes Mellitus</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>January 8, 1987</u> to <u>January 11, 1987</u> , that (I) (we) last saw the deceased alive on <u>Jan. 10, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>James E. Rowe M.D.</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>Jan. 12, 1987</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>James Rowe</u> | | | | 22e. ADDRESS
<u>413 Commonwealth Ave.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>1/14/87</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Meadowridge Mem. Park</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Elkridge Howard Md.</u> | |
| 24. FUNERAL DIRECTOR
NAME
<u>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.</u> | | | | 25a. DATE REC'D. BY REGISTRAR
<u>21229</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Gordon-Randall</u> | |

BP

JAN 15 1987

